

REG. NO.

**MEDICAL CERTIFICATION**

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE MEDICAL EXAMINER. WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PARAGRAPHS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM PM 3. REBURY PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 100 WEST MONROE STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
EDITH LOUISE ANDERSON					SEPTEMBER	5	1983		10 25 AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE	NEGRO	2 17 32		51 YRS.	MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND	U.S.A.			Wicomico MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Salisbury	Peninsula General Hospital		DISABLED LABORER		CAMPBELL SOUP				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS				
MARYLAND	WICOMICO	FRUITLAND		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	CEDAR LANE & POPLAR STREET				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
LOUIS		WILLIAMS		EDITH		ROCK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		220-26-8483		SAMUEL ANDERSON		P.O. BOX 387 FRUITLAND, MARYLAND 21826			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u>									
5860 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASHD, CAD</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal Failure</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/25</u> 19 <u>83</u> to <u>9/5</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9/3</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING MEDICAL STAFF		22c. DATE SIGNED			
<u>Constante J Tan</u>		MD		<input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN		9/5/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
CONSTANTE J TAN		547-D Riverside Dr. Salisbury Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		9-08-83		MT. CALVARY U.M. CEM.		FRUITLAND WICOMICO MARYLAND			
24. FUNERAL DIRECTOR		ROUTE #2, JERSEY RD.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
JOLLEY MEMORIAL CHAPEL		SALISBURY, MD. 21801		SEP 13 1983		<u>John J. Connel</u>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2/13/58

NAME	WIDOMSKI
ADDRESS	1000 1st Ave S
CITY	ST. LOUIS
STATE	MO
ZIP	63101
DATE	2/13/58

20% COTTON

CHILLYN

1000 1st Ave S

ST. LOUIS

MO

63101

2/13/58



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH IS SUSPECTED, THE MEDICAL EXAMINER SHOULD BE NOTIFIED IMMEDIATELY. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>RALPH CHESTER ARNER</b>							2a. DATE KNOWN OF DEATH MONTH <b>9</b> DAY <b>22</b> YEAR <b>83</b>		2b. HOUR <b>0240</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>17</b> YEAR <b>13</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>70</b> YRS.		IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>		7c. DATE PRONOUNCED DEAD MONTH <b>9</b> DAY <b>22</b> YEAR <b>83</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired pattern maker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Pa.</b> 13b. CITY OR TOWN <b>Lehigh</b> 13c. CITY OR TOWN <b>Orefield</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>Rt. 2</b>											
14. FATHER'S NAME FIRST <b>Everett</b> MIDDLE <b>J.</b> LAST <b>Arner</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Carrie</b> MIDDLE <b>Haas</b> LAST <b>Haas</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>194-07-2990</b>		17. INFORMANT ADDRESS <b>Wilma Arner, same as #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. <b>Deputy</b> MEDICAL EXAMINER				DATE SIGNED <b>9-22-83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Earl L. Foyer, M.D.</b>				ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>				23b. DATE <b>9-26-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jordan Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Walbert, Montgomery, Pa.</b> COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Baker-Bounds, Salisbury, Md.</b> ADDRESS						25a. DATE REC'D. BY REGISTRAR <b>SEP 26 1983</b>		25b. REGISTRAR'S SIGNATURE 			



4-10-10



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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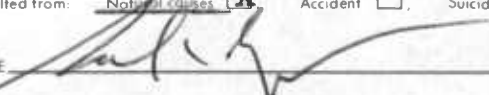

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25494

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>HARRY</b>		MIDDLE		LAST <b>BAILEY</b>		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		2b. DATE 19 <b>9-25-83</b>		2c. DATE 19 <b>9-25-83</b>		2d. HOUR <b>12:15</b>			
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3-16-1913</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>70 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE 19 <b>9-25-83</b>		7d. HOUR <b>12:15</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>				MD.			
10. CITY OR TOWN OF DEATH <b>Hebron</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt. 1, Box 175</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FARMER</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>21430</b>							
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>Wicomico</b>				13c. CITY OR TOWN <b>HEBRON</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS <b>Rt 1, Box 175 Postee Mill Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Carlton</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Palmer</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>214-12-5259</b>				17. INFORMANT ADDRESS <b>HELEN Bailey Rt 1, Box 175 Hebron, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. <b>Deputy</b> MEDICAL EXAMINER				DATE SIGNED <b>9-26-83</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>Earl L. Royer, M.D.</b>				ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>10-1-83</b>				23c. NAME OF CEMETERY OR CREMATORY <b>MARDELA Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>MARDELA Wicomico MD.</b>							
24. FUNERAL DIRECTOR NAME ADDRESS <b>Stewart Funeral Home, Salisbury, Md.</b>				25. DATE OF CERTIFICATE BY REGISTRAR <b>OCT 4 - 1983</b>				25a. REGISTRAR'S SIGNATURE 											

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Katie H. Baker			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 1 1983			2b. HOUR 0810 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 13 1897		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner	
						12b. KIND OF BUSINESS OR INDUSTRY Store	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Worcester		13c. CITY OR TOWN Bishopville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Isaac A. Davis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Wilkerson		13e. STREET ADDRESS Box 123A		21813	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-80-5922		17. INFORMANT ADDRESS Carl Baker, Bishopville, Maryland			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4860  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic Obstructive Pulmonary Disease, Chronic Renal Failure

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from 8/29 1983 to 9/1 1983, that (I) (we) last saw the deceased alive on 9/1 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Benito S. Chan		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/1/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENITO S. CHAN		22e. ADDRESS 547-D Riverchase Dr.			

23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 9-3-83		23c. NAME OF CEMETERY OR CREMATORY Odd Fellows		23d. LOCATION CITY OR TOWN COUNTY STATE Bishopville Worcester MD	
24. FUNERAL DIRECTOR NAME ADDRESS Charles W. Heston, Salisbury, Del.				25a. DATE REC'D. BY REGISTRAR SEP 6 1983			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner's office must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Mattie Dykes BALL</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>September 7, 1983</b>		2b. HOUR <b>9:00p</b>	
1. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 25 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Eden, Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Deer's Head Center</b>		12a. USUAL RESIDENCE (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Wicomico Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Eden, Md.</b>				13b. COUNTY <b>Worcester</b>		13c. CITY OR TOWN <b>Eden</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clayton E. Dykes</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Coulbourne</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-38-0900A</b>		17. INFORMANT <b>Mr. Clayton Ball</b> ADDRESS <b>Route #1 Box 62, Eden, Md. 21822</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4360 CVA Aspiration Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8-13</b> 19 <b>82</b> to <b>9-7</b> 19 <b>83</b> that (I) (we) last saw the deceased alive on <b>9-4 9-7</b> 19 <b>83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>K. Yoon, M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>9-7-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KYUNG Yoon</b>				22e. ADDRESS <b>Deer's Head Center, Salisbury, Md. 21801</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9/11/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury Wicomico Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Hollaway Funeral Home, P.A.</b>				ADDRESS <b>Salisbury, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 13 1983</b>	
				25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>			



9:00

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BALL

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iconic

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Eden, Newland

Boat's Head Center

Salisbury

Route 11

Eden, N.Y.

Conjunction

Office

Yas

Station E.

213-3-1000 Route 11 Box 2, Eden, N.Y. 11521

Eden, Newland

Eden, Newland



Boat's Head Center, Salisbury, N.Y. 11521

Salisbury, N.Y.

Salisbury, N.Y.

Salisbury, N.Y.

Salisbury, N.Y.

Salisbury, N.Y.

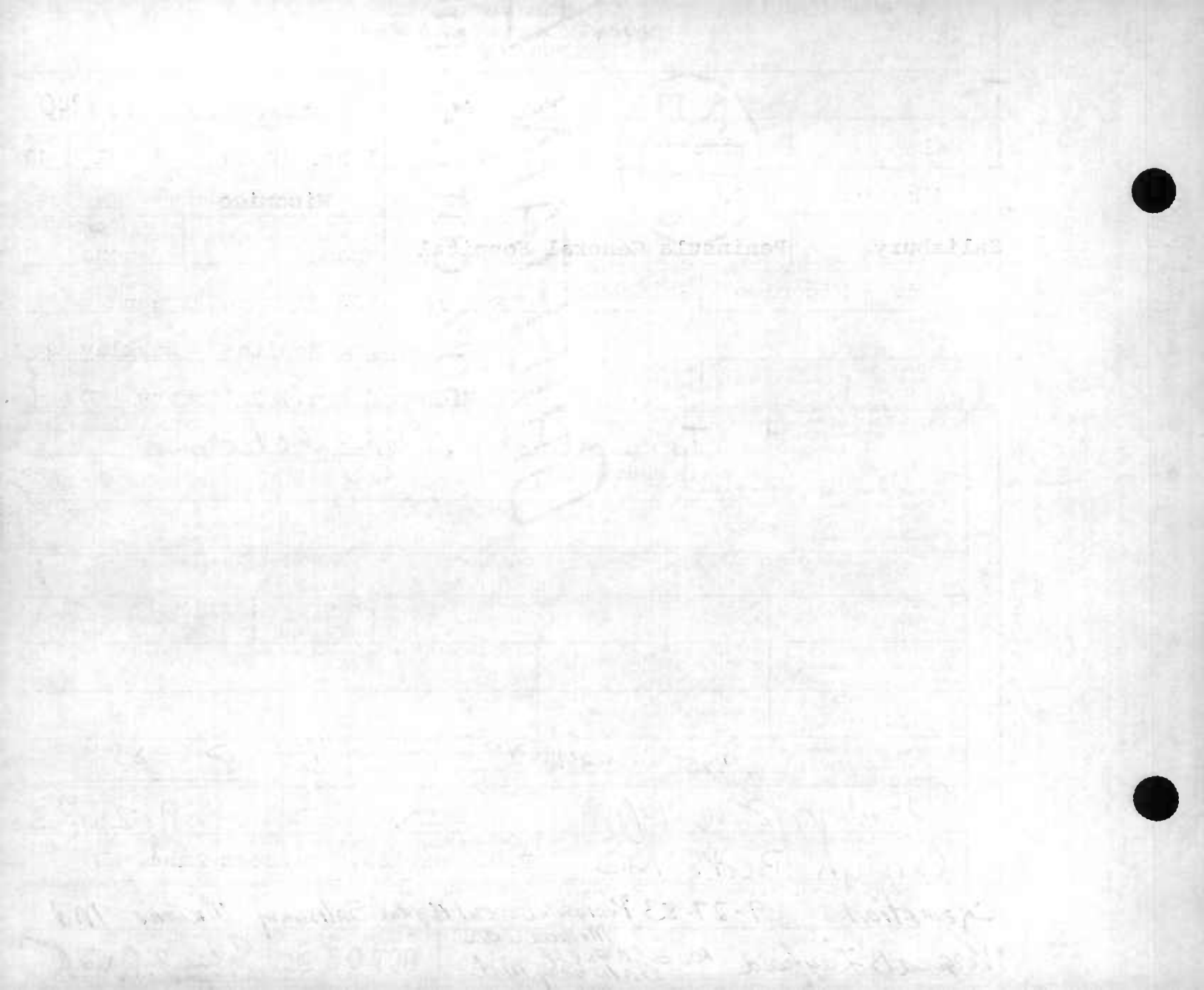
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST					MONTH DAY YEAR				
Barkley					September 25, 1983				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Male		Black		MONTH DAY YEAR		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
				Sept. 25 83		1 hr. 40 min.		1 40	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.				Wicomico MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital				none		none	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		730 Richmond Avenue 21801		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST					FIRST MIDDLE LAST				
					Karen Benita Barkley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
							730 Richmond Ave., Salisbury, MD		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Immaturity 20 to legal abortion									
7651 DUE TO, OR AS A CONSEQUENCE OF (b)									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 9/25/83 19 to 9/25/83 19 83 that (I) (we) lost the deceased alive on 9/25 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		22c. DATE SIGNED		
Carolyn Boone M.D.							9/25/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Carolyn Boone M.D.					P.O. Box 188, Princess Anne, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Cremation			9-27-83		Peninsula General Hospital		Salisbury Wicomico Md		
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Virginia B Layfield 100 E. Carroll St Salisbury Md					OCT 03 1983		John J. Carver		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Alice Borelli				2b. HOUR 1915 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 05 15 1920		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George J. Langstaff		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Stack		13e. STREET ADDRESS 716 Baker Street 21801			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 282-14-8774		17. INFORMANT ADDRESS Mr. Joseph Borelli (Husband) 716 Baker Street Salisbury, Md. 21801			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct 4100 DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) unknown APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-7, 1983, to 9-7, 1983, that (I) (we) last saw the deceased alive on 9-7, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Wilber R. Ellis Jr.				DEGREE MD		22c. DATE SIGNED 9-7-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 100 Power Street, Salisbury, Md. 21801			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/10/83		23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens Hebron		23d. LOCATION CITY OR TOWN COUNTY STATE Wicomico Md.	
24. FUNERAL DIRECTOR NAME Holloway Funeral Home, P.A. Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR SEP 13 1983		25b. REGISTRAR'S SIGNATURE John J. Smith	

BP

100-10-275-71

George A. Langstaff

George A. Langstaff

202-0-10-275-71

George A. Langstaff

George A. Langstaff

George A. Langstaff

George A. Langstaff

George A. Langstaff

REG. NO.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

23a. BURIAL, CREMATION, REMOVAL (FURNITURE) <i>Burial</i>	23b. DATE <i>9-20-83</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Christian</i>	23d. LOCATION CITY OR TOWN <i>Snow Hill, Maryland</i> COUNTY STATE
24. FUNERAL DIRECTOR NAME <i>Norman F. Dennis</i> ADDRESS <i>Snow Hill, Md.</i>		25a. DATE RECEIVED BY REGISTRY <i>SEP 22 1983</i>	25b. REGISTRAR'S SIGNATURE <i>John J. Lamm</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ALBERT F. BREWSTER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9/12/83</b>			2b. HOUR M				
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 23, 1942</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>41</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEWHALL W. VA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>WICOMICO</b> MD.				
10. CITY OR TOWN OF DEATH <b>SALISBURY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>SANTEE FE DR. RD 2</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS) <b>RETIRED ROOFER</b>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>WICOMICO</b>		13c. CITY OR TOWN <b>SALISBURY</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>SANTEE FE DR. RD 2</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES BREWSTER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ALICE GRAHAM</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-40-8873</b>		17. INFORMANT ADDRESS <b>CHRISTINE BREWSTER (SEE # 13e)</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4280</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardio pulmonary Arrest</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>NWS</b> <b>YRS</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (he/she) attended the deceased from <b>4/13</b> , 19 <b>81</b> , to <b>9/12</b> , 19 <b>83</b> , that (I/we) lost saw the deceased alive <input checked="" type="checkbox"/> above, (I/we) (did) (did not) view the body after death. <input checked="" type="checkbox"/> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated										
22b. SIGNATURE <b>Donald M. Wood MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>9/12/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DONALD M. WOOD MD</b>			22e. ADDRESS <b>PGHMC</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>9/16/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARSONS CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SALISBURY, MD.</b>			
24. FUNERAL DIRECTOR <b>WILSON FUNERAL HOME SALISBURY, MD</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 14 1983</b>				
						25b. REGISTRAR'S SIGNATURE <b>John J. Cunniff</b>				



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

25501

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>ALICE M Berthingham</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9 16 83</i>		2b. HOUR <i>12 15 P.M.</i>		
3. SEX <i>F</i>		4. RACE <i>BK</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 03 13</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>70</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Frankford Del</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> MD.	
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Domestic</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
13a. STATE <i>Md</i>				13b. COUNTY <i>Worcester</i>		13c. CITY OR TOWN <i>Berlin</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John McCray</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bertha Tarr</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>222-01-7546</i>	
17. INFORMANT ADDRESS <i>Bertha Jacobs 36 Browning Ave. Trenton, N.J.</i>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>RESPIRATORY ARREST</i> <i>1830</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>STAGE IV OVARIAN CARCINOMA</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>MONTHS</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>1830</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 7</i> , 19 <i>83</i> , to <i>Sept 16</i> , 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>Sept 16</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Paul R Fleury</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/16/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PAUL R FLEURY</i>				22e. ADDRESS <i>305 TENTH ST Pocomoke City Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>9-21-83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Evergreen</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Berlin Worc. Md.</i>	
24. FUNERAL DIRECTOR <i>Volley Memorial Chapel Rt #2 Salis. Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>SEP 23 1983</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

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California Peninsula General Hospital

Wisconsin

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 25502			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) <b>ELsie M. BUNTING</b>				2b. HOUR <b>1647</b>			
2. SEX <b>FEMALE</b>		3. RACE <b>WHITE</b>		4. DATE OF BIRTH MONTH DAY YEAR <b>11 19 1894</b>		5. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>		7. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Wicomico</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>605 N. Division Street 21801</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter P. McCabe</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Hastings</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-44-7210</b>		17. INFORMANT ADDRESS <b>Mr. Bennett D. Robertson, son-in-law 925 N. Division St., Salisbury, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hepatic Coma, 20 to probable</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>metastatic carcinoma</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>9-10</b> , 19 <b>83</b> , to <b>9-15</b> , 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>9-15</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Michael E. Crouch</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>9-15-83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael E. Crouch</b>				22e. ADDRESS <b>531 Riverside Dr., Salisbury, Md. 21801</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/19/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury Wicomico Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Holloway Funeral Home, P.A. Salisbury, md.</b> ADDRESS				25a. DATE REC'D. BY REGISTRAR <b>SEP 19 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Crouch</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Katie STAGG BUTLER			2a. DATE OF DEATH MONTH DAY YEAR September 26, 1983		2b. HOUR 9:18 PM	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JAN 21, 1893	6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Int. Domestic Helper		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.	13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 200 Pryor Ave		
14. FATHER'S NAME FIRST MIDDLE LAST Montgomery STAGG		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy POLLITT				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 222-12-1345	17. INFORMANT ANNA LEE TRADER		ADDRESS 309 Morris Dr. Salisbury Md 21801		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic ca. in colon 1952 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Edward Peyton Ritchings, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/26/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward Peyton Ritchings, M.D.		22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801				
23a. BURIAL, CREMATION, REMOVAL (TYPE)	23b. DATE 9/29/1983	23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Sussex DE		
24. FUNERAL DIRECTOR NAME Baker & Bounds, Salisbury Md		24b. ADDRESS SEP 29 1983				



2:18 PM

October 11, 1961

Dr. J. H. ...

Dr. J. H. ...

Dr. J. H. ...

Dr. J. H. ...

Dr. J. H. ...

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Dr. J. H. ...



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Dr. J. H. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examiner's certificate must be attached to this certificate.

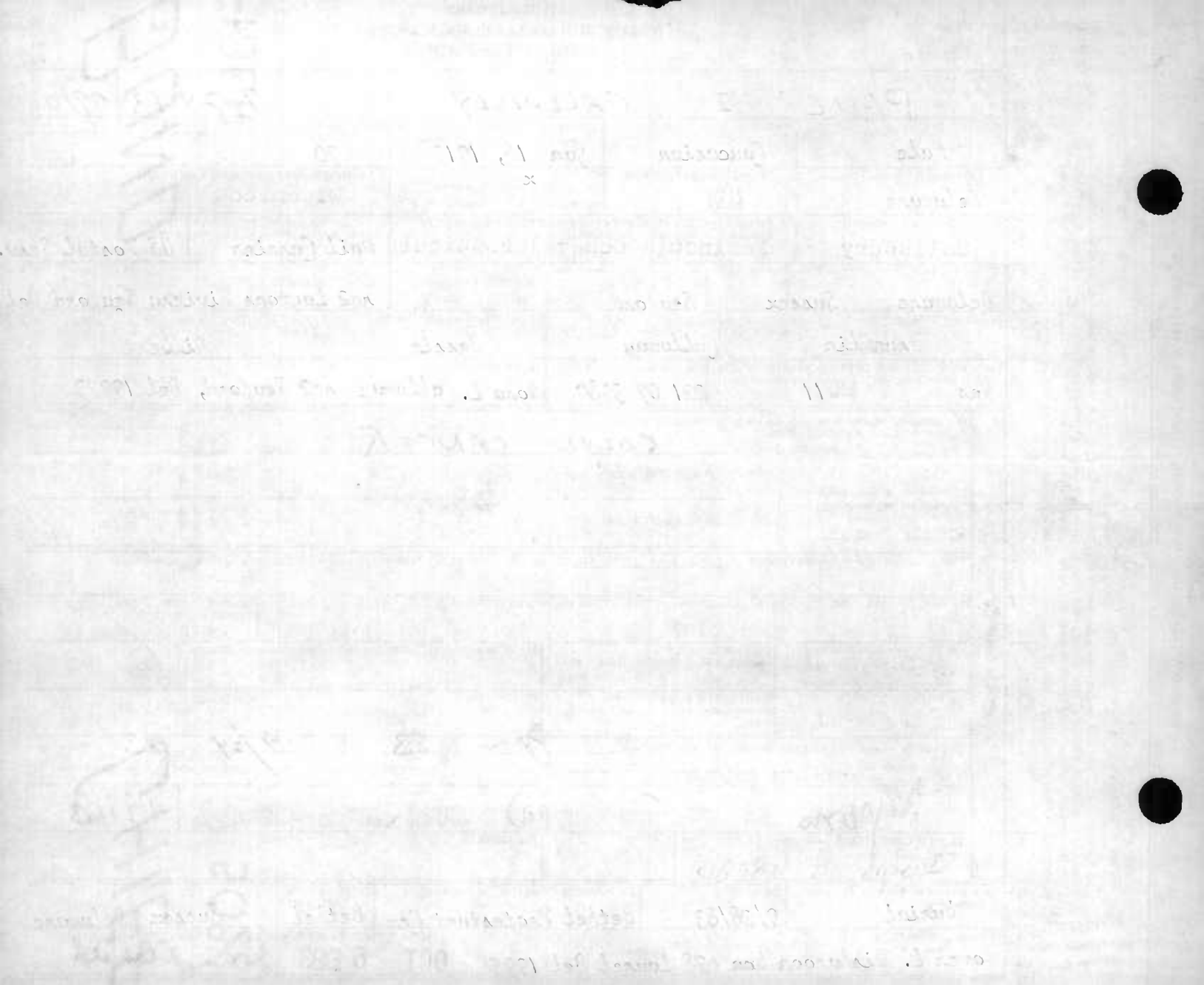
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 25504

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>PAUL I CALLAWAY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 24 83</b>			2b. HOUR <b>0910 M</b>				
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 18, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.				
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mail Carrier</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US Postal Serv.</b>		
13a. STATE <b>Delaware</b>		13b. COUNTY <b>Sussex</b>		13c. CITY OR TOWN <b>Seaford</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Franklin Callaway</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Gilbert</b>				13e. STREET ADDRESS / ZIP CODE <b>rd2 Laytons Riviera Seaford Del 99999</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>UNU71</b>		17. INFORMANT <b>Nora L. Callaway</b>		ADDRESS <b>rd2 Seaford, Del 19973</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1539 IMMEDIATE CAUSE (a) COLON CANCER</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 83</b> to <b>9/24 19 83</b> that (I) (we) lost saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Joseph A. Grasso</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/27/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph A. Grasso</b>			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9/28/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Protestant Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bethel Sussex Delaware</b>			
24. FUNERAL DIRECTOR NAME <b>Homer L. Disharoon</b>					ADDRESS <b>box 678 Laurel Del 19956</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 6 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

FOR  
 1 - STATE  
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John Edmund Causey			2a. DATE OF DEATH MONTH DAY YEAR September 7, 1983			2b. HOUR M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02 04 1894		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.		
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Watchmaker		
12b. KIND OF BUSINESS OR INDUSTRY								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS Old Ocean City Road		21801						
14. FATHER'S NAME FIRST MIDDLE LAST John Sam Causey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Hopkins				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI & WWII		17. INFORMANT Gordon Gladden 1301 Whittier Drive, Salisbury, Maryland				
16c. ADDRESS 21801								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcine arrest due to metastatic</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>chronic obstructive Pulmonary disease</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>10/15</u> , 19 <u>77</u> , to <u>9/7</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>9/7</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Joseph Z. Sadron</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Joseph Badros				22e. ADDRESS 229 Florida Avenue, Salisbury, Md. 21801				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/10/83		23c. NAME OF CEMETERY OR CREMATORY Asbury Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Vernon Somerset Md.		
24. FUNERAL DIRECTOR NAME Holloway				ADDRESS P.A. Salisbury, Md.		25a. DATE REC'D. BY REGISTRAR SEP 13 1983		
				25b. REGISTRAR'S SIGNATURE <u>John J. Causey</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off, item 48 shows any injury, or other traumatic event, the medical examiner must be notified of one.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RAMONA G. COLLINS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 3 83</b>			2b. HOUR <b>1010<sup>M</sup></b>	
3. SEX <b>Female</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 9, 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>DELAWARE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	
12b. KIND OF BUSINESS OR INDUSTRY							

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>DELAWARE</b>			13b. COUNTY <b>SUSSEX</b>		13c. CITY OR TOWN <b>SELBYVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 1 Box 119 99999</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>LAMBERT LYNCH</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MYRTLE HUDSON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>222-20-4154</b>			17. INFORMANT ADDRESS <b>IRA L. COLLINS, SELBYVILLE, DE</b>				

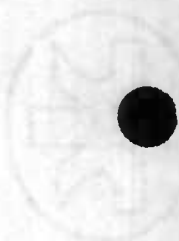
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anger lympho blast lymphoma</b> <b>2049</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

**Recurrent Pneumonia**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE <b>SELBYVILLE SUSSEX DE</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/1/83</b> to <b>9/3/83</b> , that (I) (we) last saw the deceased alive on <b>9/1/83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9-5-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LYNCH CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>DAYARD, SUSSEX DE</b>	
24. FUNERAL DIRECTOR <b>Charles W. Hartman, Selbyville, Del.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 9 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>	





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25507

REG. NO.

1- FOR  
STATE  
REGISTRAR

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED		MONTH	DAY	YEAR	2b. HOUR
DONALD L. COOK					9-11-83					0500
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR	2d. HOUR
male	white	7/24/31		32			9-11-83			11
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
New York		U.S.A.				Wicomico				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury		Peninsula General Hospital				heavy equip. operator				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
Del.		Sussex		Frankford				Rt. 3 Box 244 99999		
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Lawrence Cook				Olive Cook						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
no		074-26-5720		Victoria Whitehead - Frankford, De.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER				DATE SIGNED 9-12-83				
EXAMINER'S NAME (TYPE OR PRINT)		Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		9/15/83		Valley Home Cem.		Windham, Pennsylvania				
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Watson Funeral Home, Millsboro, De.				SEP 16 1983		John J. Carver				

MEDICAL CERTIFICATION



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) June Virginia Brown Cooper			2a. DATE OF DEATH MONTH DAY YEAR September 15 1983			2b. HOUR 1548 M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 12, 1915	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retail clerk		12b. KIND OF BUSINESS OR INDUSTRY dept. store	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Wicomico	13c. CITY OR TOWN Berlin	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 28 Bird Nest Drive 21811	
14. FATHER'S NAME FIRST MIDDLE LAST Charles C. Brown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Stewart				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-14-1123		17. INFORMANT ADDRESS Gary T. Cooper 5864 Conte Dr. Lothian, Md. 20711			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4100 congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>myocardial infarction, inferior</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 days</u>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>ANTERIOR MYOCARDIAL INFARCTION NOVEMBER 1982</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from <u>9-9-</u> 19 <u>83</u> , to <u>9-15</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9-15</u> 19 <u>83</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>John Kelleman MD</u> 22a. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN J. KELLEMAN	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9-15-83
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept 19, 1983	23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Lovettsville, Va. (Loudoun)
24. FUNERAL DIRECTOR NAME Brown Funeral Home		ADDRESS P.O. Box 320 Lovettsville, Virginia	25a. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE SEP 22 1983 <u>Sam J. Gault</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

BP

12-10-1944

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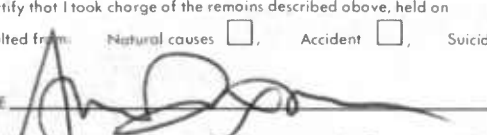

12-10-1944

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

25509

1- FOR  
STATE  
REGISTRAR

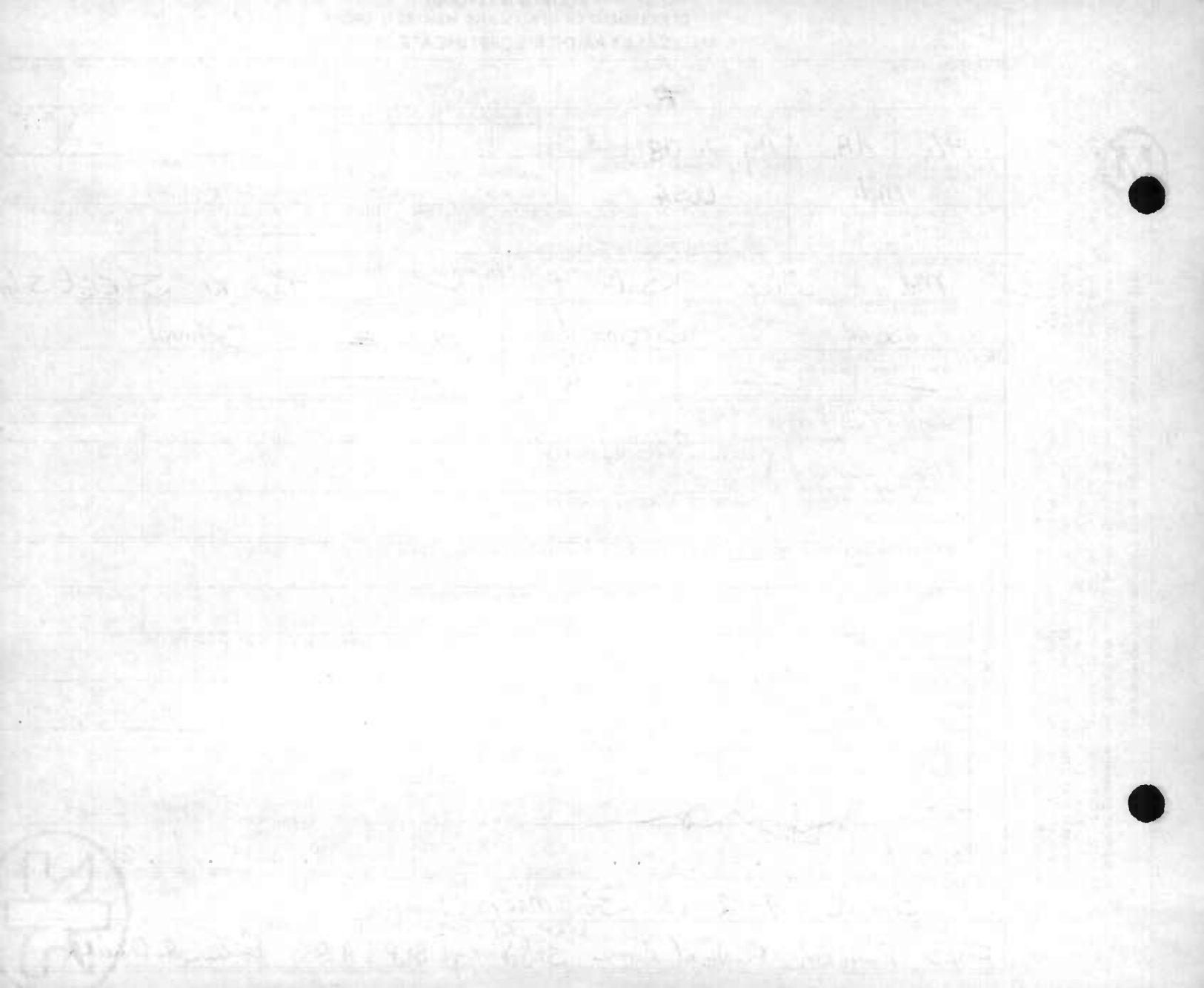
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>OSCAR R. COTTMAN</b>				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>9 7 1983</b>				2b. HOUR <b>8:15 PM</b>	
3. SEX <b>MALE</b>	4. RACE <b>AA</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug 21 1980</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>3</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>9 7 1983</b>		2d. HOUR <b>8:15 PM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico County</b>			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>md</b>		13b. COUNTY <b>Wico</b>		13c. CITY OR TOWN <b>Salis</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>TANGIER STREET Salis</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>OSCAR Cottman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ARMICE Cottman</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. <b>UNK</b>		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of head (rifle)</b> 9652 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 9-7- 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject was shot.</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>house</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>527 Tangier St., Salisbury, Wicomico, Md.</b>					
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>9-8-83</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-12-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Mary's Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Forks Funeral Home Salisbury</b>				DATE REC'D. BY REGISTRAR <b>SEP 14 1983</b>		REGISTRAR'S SIGNATURE 			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

25510

1. DECEASED NAME (TYPE OR PRINT) <b>Margaret R. Cullen</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 15 1983</b>			2b. HOUR <b>2220</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 27, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>69 8 18</b>		7. IF UNDER 1 YEAR HOURS MIN. <b>22 20</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico MD.</b>			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Elm. School</b>	
13a. STATE <b>Delaware</b>			13b. CITY OR TOWN <b>Sussex</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>405 Delaware Avenue 9999</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Wilson Remaley</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rowena Walter Remaley</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>194-20-9071</b>		17. INFORMANT ADDRESS <b>Charles M. Cullen Delmar, Del. 19940</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1629 Carcinoma of Lung</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Congestive Heart Failure.</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>9.15</b> , 19 <b>83</b> , to <b>9.15</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>9.15</b> , 19 <b>83</b> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did not) view the body after death.									
22b. SIGNATURE <b>K. C. Merrill</b>					DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/17/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9-19-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Roxana Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Roxana Sussex Delaware</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Marvel-Short Funeral Home Delmar, Del.</b>					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>		



September 15, 1933

Letter

Dear Sir,

Thank you

very

much for

information

concerning

the school

and the

new building

which is

being

constructed

at the

present site.

Sincerely,

W. H. Smith

W. H. Smith

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
2004 4/02

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 25511	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>JOHNNIE CURTIS</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>9-16-83</b>	
3. SEX <b>M</b> 4. RACE <b>N</b> 5. DATE OF BIRTH MONTH DAY YEAR <b>July 24/95</b> 6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS. IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.										2b. HOUR <b>1155</b> M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b> 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2c. DATE PRONOUNCED DEAD <b>9-16-83</b> 19	
10. CITY OR TOWN OF DEATH <b>Salisbury</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Waterman</b>										2d. HOUR <b>"</b> M	
13a. STATE <b>Md</b> 13b. COUNTY <b>Som</b> 13c. CITY OR TOWN <b>Chance</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Curtis</b> 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mamie White</b>										12b. KIND OF BUSINESS OR INDUSTRY <b>seafood</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b> (IF YES, GIVE WAR OR DATES) <b>WW I</b> 16b. SOCIAL SECURITY NO. <b>220-03-6332</b> 17. INFORMANT ADDRESS <b>21816</b>										13e. STREET ADDRESS <b>21816</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Multiple Trauma</b> IMMEDIATE CAUSE (a) <b>Multiple Trauma</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>1000 P.M. 9-16-83</b>										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver of auto struck by trailer truck</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <b>highway, Rt. 13 &amp; 675, nr. Princess Anne, Som., Md.</b>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>highway, Rt. 13 &amp; 675, nr. Princess Anne, Som., Md.</b>	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Chance Som Md</b>											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b> TITLE (SPECIFY) <b>Deputy</b> M.D. MEDICAL EXAMINER										DATE SIGNED <b>9-19-83</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Earl L. Royer, M.D.</b> ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b> 23b. DATE <b>9/19/83</b> 23c. NAME OF CEMETERY OR CREMATORY <b>St. Charles Cemetery</b>										23d. LOCATION CITY OR TOWN COUNTY STATE <b>Chance Som Md</b>	
24. FUNERAL DIRECTOR NAME <b>Reroy Webster</b> ADDRESS <b>21816</b>										25a. DATE REC'D. BY REGISTRAR <b>SEP 22 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP \_\_\_\_\_

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EVELYN ELIZABETH DENNIS			2a. DATE OF DEATH MONTH DAY YEAR 9 13 1983			2b. HOUR 6:10 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 08 23 1923		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Powellville, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.	
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Legal Secretary	
13a. STATE Maryland				13b. COUNTY Wicomico		13c. CITY OR TOWN Powellville	
14. FATHER'S NAME FIRST MIDDLE LAST David William Dennis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Rayne			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-16-7270		17. INFORMANT Mrs. Myrtle R. Dennis, Mother Powellville, Md. 21850			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) <u>CA Breast</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Generalized Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Three years</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) see the body after death.							
22b. SIGNATURE James P. Gallaher, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/13/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES P. GALLAHER, MD.				22e. ADDRESS SALISBURY, MD. 21801			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/16/83		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Powellville Wicomico Md.	
24. FUNERAL DIRECTOR NAME Holloway Funeral Home, P.A.				ADDRESS Salisbury, Md.		25a. DATE REC'D. BY REGISTRAR SEP 16 1983	
				25b. REGISTRAR'S SIGNATURE John J. Cawich			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				25514			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH ELOISE DOWNING Downing				2a. DATE OF DEATH MONTH DAY YEAR 9 17 83			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 05 1904		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS 108 E. London Avenue 21801			
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Delos Cutright				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Haskins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-20-7163		17. INFORMANT Mrs. Pauline D. Walsh (Daughter) Rte #3 Mt. Hermon Rd., Salisbury, Md. 21801			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4329 Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Intracranial Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 48 hrs.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/16, 19 83 to 9/17, 19 83, that (I) (we) last saw the deceased alive on 9/17, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Daniel W. Moore M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/17/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL W. MOORE M.D.				22e. ADDRESS PGH Medical Center			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/20/83		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Holloway Funeral Home, P.A. Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR SEP 26 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 25515									
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 9 24 83					2b. HOUR 600 PM				
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna Ramm English					3. SEX FEMALE					4. RACE WHITE				
5. DATE OF BIRTH MONTH DAY YEAR 10 31 98					6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.					7. IF UNDER 1 YEAR MONTHS DAYS				
8. IF UNDER 24 HRS. HOURS MIN.					9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.					10. CITY OR TOWN OF DEATH Salisbury				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RIVER WALK MANOR					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE					12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13a. STATE Maryland					13b. COUNTY Wicomico					13c. CITY OR TOWN Salisbury				
14. FATHER'S NAME FIRST MIDDLE LAST CLARENCE HORN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA (UNKNOWN)					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				
16b. SOCIAL SECURITY NO. 213-74-3630					17. INFORMANT ADDRESS 286 SUSSEX RD. Ocean City, Md 21842					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma 1749				
DUE TO, OR AS A CONSEQUENCE OF (b) carcinoma breast, recurrent					DUE TO, OR AS A CONSEQUENCE OF (c) carcinoma breast					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) congestive failure					19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY? YES NO					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES NO					21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK				
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE					22a. I certify that (I) (this hospital) attended the deceased from 1-27 19 82, to 9-24 19 83, that (I) (we) last saw the deceased alive on 9-24 19 83, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE John F. Bulkeley M.D.					DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN					22c. DATE SIGNED 9-25-83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John F. Bulkeley					22e. ADDRESS Pine Bluff Rd. Salisbury, Md. 21801					23a. BURIAL, CREMATION, REMOVAL (TYPE) BURIAL				
23b. DATE 9/27/1983					23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Pk.					23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Md.				
24. FUNERAL DIRECTOR NAME Baker And Bounds, Salisbury, Md.					25a. DATE REC'D. BY REGISTRAR 28 SEP 1983					25b. REGISTRAR'S SIGNATURE [Signature]				

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REG. NO

**MEDICAL CERTIFICATION**

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



Form 1-47-1952

W-28

Continuation of Form 1-47-1952

Maryland, Westmore, Harrison, \* 84-2 Box 257 Falls MD

John Henry Cook L.H.E. Robinson

No 219-02-3725 Queen River 84-2 Box 257 Falls MD

Indicate due to on 11/1/52



11-1-52

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Bureau 9-17-52 1-47-1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>HUBERT W. FREEMAN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 15-1983</b>			2b. HOUR <b>0210M</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 3 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Phila, Pa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.					
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Wicomico</b> 13c. CITY OR TOWN <b>Hebron</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Memory Garden Lane 21830</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Robert Freeman</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kathryn Freeman</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes Navy</b>		16b. SOCIAL SECURITY NO. <b>213-22-7245</b>		17. INFORMANT ADDRESS <b>Mrs. Elizabeth Freeman (see 13e)</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: <b>4292 IMMEDIATE CAUSE (a) Cardiac Arrest</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>YRS</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE	
22a. I certify that (b) (this hospital) attended the deceased from <b>9/6</b> , 19 <b>83</b> , to <b>9/15</b> , 19 <b>83</b> , that (b) (we) last saw the deceased alive on <b>9/6</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Arnold M. Gums</b>					DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/16/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D.M. Wood, MD</b>					22e. ADDRESS <b>POTOMAC</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9/17/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Springhill Mem Garden</b>			23d. LOCATION CITY OR TOWN <b>Hebron</b>		COUNTY STATE <b>Wic Md</b>	
24. FUNERAL DIRECTOR NAME <b>Wilson Funeral Home Salisbury, Md</b>					25a. DATE REC'D. BY REGISTRAR <b>SEP 19 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Lander</b>				





Yes Navy  
213-32-225 Mrs. Elizabeth Wilson (nee Lee)  
Dorothy Roberts  
William Wilson  
A. Henry Earl on June 21-30

Wilson Trust  
A. H. Wilson  
Elizabeth M. Wilson  
Mrs. Wilson  
Wilson Trust  
A. H. Wilson  
Elizabeth M. Wilson  
Mrs. Wilson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#4, Film 584 10/31/83 kam

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

25518

1. FOR STATE REGISTRAR		REG. NO.	
1a. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Charles E Gochnour		MONTH DAY YEAR 09 01 83	
3. SEX		2b. HOUR	
Male		0915 M	
4. RACE		6. AGE (IN YEARS LAST BIRTHDAY)	
White		75 YRS.	
5. DATE OF BIRTH		IF UNDER 1 YEAR	
MONTH DAY YEAR SEPT. 2, 1907		MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		IF UNDER 24 HRS	
MD.		HOURS MIN.	
7b. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH	
U.S.A.		Wicomico MD.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
10. CITY OR TOWN OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		RETIRED	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			
Peninsula General Hospital			
13a. STATE		13b. INSIDE CITY LIMITS?	
MD.		YES <input type="checkbox"/> NO <input type="checkbox"/>	
13c. CITY OR TOWN		13d. STREET ADDRESS	
WICOMICO PARSONSBURY		R.F.D. BOX. 90 21849	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST CHARLES GOCHNOUR		FIRST MIDDLE LAST NORA COLES	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
NO		214-10-7844	
17. INFORMANT		ADDRESS	
MRS. FRANCES GOCHNOUR		SEE #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Respiratory Arrest			
1629 DUE TO, OR AS A CONSEQUENCE OF			
(b) Pneumonia			
DUE TO, OR AS A CONSEQUENCE OF			
(c) Probable bronchogenic Carcinoma			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
Right Hemispheric CVA Malnutrition			
19a. DATE OF OPERATION		20a. AUTOPSY?	
		YES <input type="checkbox"/> NO <input type="checkbox"/>	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED		21e. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE	
21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
22a. I certify that (I) (this hospital) attended the deceased from 21 August 1983, to 1 Sept 1983, that (I) (we) last saw the deceased alive on 31 Aug 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22c. DATE SIGNED	
22b. SIGNATURE		1 Sept 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
William A. Godfrey		P.O. Box 40 Princess Anne, Md 21853	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
BURIAL		9/6/83	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
PARSON CEMETERY		CITY OR TOWN COUNTY STATE SALISBURY, MD.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
NAME ADDRESS WILSON FUNERAL HOME SALISBURY, MD.		25b. REGISTRAR'S SIGNATURE	
		SEP 7 1983	

WILSON YOUNG FOR BALLOT, MD.

8/5/52



200% COTTON  
WILSON YOUNG

BALLOT, MD.

NO. 10

1952

WILSON YOUNG  
BALLOT, MD.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 25519

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Pauline T Godfrey			2a. DATE OF DEATH MONTH DAY YEAR 9/13/83			2b. HOUR 12 <sup>25</sup> P.M.				
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 10 29 1906		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.				
10 CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RIVERWALK MANOR NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED SEAMSTRESS		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY WICOMICO		13c. CITY OR TOWN SALISBURY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST JAMES THOMPSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE ADAMS			13e. STREET ADDRESS 212 E. LINCOLN AVENUE 21801				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 214-10-9598		17. INFORMANT ADDRESS Mr. Welton R. Godfrey, Husband 212 E. Lincoln Avenue, Salisbury, Md. 21801					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u> 4 yrs DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Chronic gastric outlet obstruction - reflux - organic brain</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>12-30</u> , 19 <u>82</u> , to <u>9-13</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9-13</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>John G. Bulkeley</u> JOHN G. BULKELEY, M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-14-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS S. SALISBURY BLVD., SALISBURY, MD. 21801							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9/16/83		23c. NAME OF CEMETERY OR CREMATORY PARSONS CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE SALISBURY WICOMICO MD		
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, P.A. SALISBURY, MD.					25a. DATE REC'D. BY REGISTRAR SEP 16 1983		25b. REGISTRAR'S SIGNATURE <u>John G. Bulkeley</u>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Clara W. GOSWELLEN</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>SEPTEMBER 25 1983</i>			2b. HOUR <i>10:15</i> M				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2-22-1893</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>90</i> YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Delaware</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> MD.				
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>House Wkr</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own Home</i>		
13a. STATE <i>Mt</i>			13b. COUNTY <i>Wicomico</i>		13c. CITY OR TOWN <i>Salisbury</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>501 Anne St. 21801</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph Downes</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Jeannette Duker</i>				16. ADDRESS <i>2904 Ocean City Rd. Eliz Padua Salisbury, MD 21801</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>-</i>		17. INFORMANT <i>Eliz Padua</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pneumonia, angiotensin heart failure</i> <i>4860</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>9/25</i> 19 <i>83</i> , to <i>9/25</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>9/25</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>M Ben Horner MD</i>			DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>9/25/83</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W BEN HORNER</i>			22e. ADDRESS <i>100 POWER STREET SALISBURY MD 21801</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>9/28/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Wic. Mem. Cem.</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Salisbury Wic. Md.</i>		
24. FUNERAL DIRECTOR NAME <i>C. M. Smith, Bivallie, MD</i>					25a. DATE REC'D. BY REGISTRAR <i>SEP 27 1983</i>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST (TYPE OR PRINT) <u>Evelyn Parsons Graham</u>				2b. HOUR <u>1620M</u>			
3. SEX <u>FEMALE</u>		4. RACE <u>white</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>1 28 1907</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>76</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Wicomico</u> MD.	
10. CITY OR TOWN OF DEATH <u>Salisbury</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Peninsula General Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired Book Keeper</u>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>Wicomico</u>		13c. CITY OR TOWN <u>Salisbury</u>		13e. STREET ADDRESS <u>218 South Blvd 21801</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>J. Henry Parsons</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Stella Parker</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>214-10-9290</u>		17. INFORMANT ADDRESS <u>6825 S. CINCINNATI ST STURAT, FLA 33494</u> <u>WALTON J. PARSONS</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5698 recurrent small bowel obstruction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>peptic ulcer disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <u>Aug. 23, 1983</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>obstructed terminal ileum</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/10</u> , 19 <u>83</u> , to <u>9/10</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>9/10</u> , 19 <u>83</u> , and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Rodney A. W. Wenrich</u> DEGREE <u>MD.</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/10/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RODNEY A. WENRICH</u>				22e. ADDRESS <u>100 POWER ST., SALISBURY, Md. 21801</u>			
23a. BURIAL, CREMATION, REMOVAL (50% FV) <u>BURIAL</u>		23b. DATE <u>9/13/1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARSONS Cem</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Salisbury Wic. Md</u>	
24. FUNERAL DIRECTOR NAME <u>BAKER &amp; BOUNDS</u> ADDRESS <u>SALISBURY, MD 21801</u>				25. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE) <u>SEP 14 1983</u>			

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1948-1949

*[Faint handwritten text]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
JAMES D. CREWE, Sr.		JAMES	D.	CREWE, Sr.	SEPTEMBER 5	1983			1035A.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 MRS.		
M	W	MONTH DAY YEAR 5 11 22		61 YRS.	MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia	USA			Wicomico MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury	Peninsula General Hospital			electrician					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE MD					13b. STREET ADDRESS 21851				
13c. CITY OR TOWN POCOMOKE					13e. STREET ADDRESS 100 Berwick Circle				
14. FATHER'S NAME FIRST MIDDLE LAST Eddie Crewe					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl Jordon				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW2					16b. SOCIAL SECURITY NO. 229 18 9800				
17. INFORMANT ADDRESS 100 Berwick Circle Bamam E. Crewe Pocomoke City, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ATHEROSCLEROTIC CORONARY ARTERY DISEASE YEARS DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 35 mins.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8-29, 1983, to 9-5, 1983, that (I) (we) last saw the deceased alive on 9-1, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John Kelleman, M.D.					DEGREE MD			22c. DATE SIGNED 9-5-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN KELLEMAN, M.D.					22e. ADDRESS Pocomoke City, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			9/7/83		Salem Methodist Cem. Pocomoke		Worcester Md.		
24. FUNERAL DIRECTOR NAME Scott S. Nelson					ADDRESS Pocomoke City, Md.		25a. DATE REC'D. BY REGISTRAR SEP 9 1983		
					25b. REGISTRAR'S SIGNATURE John J. Gansh				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 25523			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 9 20 83			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grace F. Eldridge				2b. HOUR 8 <sup>45</sup> M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 16 06		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James R. Finley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Kingan		13e. STREET ADDRESS 620 Worcester Road		13f. CITY OR TOWN 21204	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 163-34-0490		17. INFORMANT Edson D. Eldridge		ADDRESS 620 Worcester Road Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <i>cardiac arrest</i>							
4100							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b) <i>arteriosclerotic myocardial infarction</i>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/20 9/18, 19 83, to 9/20 9/20, 19 83, that (I) (we) last saw the deceased alive on 9/20 9/20, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W. B. Hanner MD				DEGREE		22c. DATE SIGNED 9/20/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. B. Hanner MD				22e. ADDRESS 100 POWER ST SALISBURY MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-24-83		23c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Ten Hills, Allegheny, Pa.	
24. FUNERAL DIRECTOR NAME Marzullo Funeral Service				ADDRESS Reisterstown, Md.		25a. DATE REC'D. BY REGISTRAR SEP 23 1983	
				REGISTRAR'S SIGNATURE John J. Casper			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.				
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLA McLAIN Grier					September 8 1983 01:22 M				
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 2 26 1893		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. STATE MARYLAND 13b. COUNTY Wicomico 13c. CITY OR TOWN Salisbury					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 214 N. CLairmont Dr		
14. FATHER'S NAME FIRST MIDDLE LAST LARNER T. McLAIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JAMES ANNA Leatherbury							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 214-46-3879		17. INFORMANT ADDRESS DAVID A. Grier 1513 Rolling Rd Salisbury, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4340 Central Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Approximate Interval Between Onset and Death 32 hrs Years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Carcinoma of Lung									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from Feb 19 68, to Sept 8 19 83, that (1) (we) last saw the deceased alive on Sept 7 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thomas C. Hill Jr. M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/8/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS C. HILL JR.					22e. ADDRESS Pine Bluff Road, SALISBURY, MD.				
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 9/10/1983		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic MD			
24. FUNERAL DIRECTOR NAME ADDRESS BAKER & BOUNDS Salisbury, MD 21801					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 13 1983 James J. Conner				



1943-1944

1945-1946

1947-1948

1949-1950

1951-1952

1953-1954

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 25525	
1. DECEASED NAME (TYPE OR PRINT) <b>HARRY L. HAMMOND</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>9 5 83</b>		2b. HOUR <b>0525</b>			
3. SEX <b>Male</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 11 28</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>9 5 19 83</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>WICOMICO</b> MD.		
10. CITY OR TOWN OF DEATH <b>SALISBURY</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PENINSULA GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Employee</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Country Club</b>	
13a. STATE <b>MD.</b>			13b. COUNTY <b>WICOMICO</b>		13c. CITY OR TOWN <b>EDEN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>RT. 1 BOX C 10</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Hammond</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Fisher</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>221 18 3247</b>			17. INFORMANT ADDRESS <b>Jeanette W. Hammond, Same as 13e.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>ARTEROSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 Hr.</b> <b>5 Yrs.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>PREVIOUS MYOCARDIAL INFARCTIONS</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John T. Bulkeley</b>			TITLE (SPECIFY) <b>DEPUTY</b>			MEDICAL EXAMINER			DATE SIGNED <b>9-5-83</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN T. BULKELEY</b>			ADDRESS <b>SALISBURY, MARYLAND</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>9/8/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Springhill Memory Gdn.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hebron, Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Baker and Bounds Funeral Home, Salisbury, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 8 1983</b>			25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>		

2. 1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Ray W. HARRISON</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>Sept. 9, 1983</b>			2b. HOUR <b>3 p.m.</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 08, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kent Co. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico MD.</b>			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Deer's Head Center, Salisbury, MD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer Various</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Dorchester</b> 13c. CITY OR TOWN <b>Cambridge</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Gay St. 21613</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles H. Harrison</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nettie BOYER</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>215 36 1850</b>		17. INFORMANT ADDRESS <b>Jeannette Gibson 212 Baltimore, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>senile degeneration</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4292 } DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>AscVD, Parkinsonism, Ex @ Hip</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital attended the deceased from <b>Aug. 10</b> , 19 <b>83</b> , to <b>Sept. 9</b> , 19 <b>83</b> , that (1) (we) lost <input checked="" type="checkbox"/> saw the deceased alive on <b>Sept. 9</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (2) we (did) (did not) view the body after death.									
22b. SIGNATURE <b>E. P. Ritchings, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>9/9/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E. P. Ritchings, M.D., Deer's Head Center, P. O. Box 2018, Salisbury, MD 21801</b>				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>9/12/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rock Hall, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>W. Willis Wells</b>				24b. ADDRESS <b>Chestertown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				25527			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEON L. Harrow				2a. DATE OF DEATH MONTH DAY YEAR September 3, 1983		2b. HOUR 0500	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 14 1912		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 71	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Electrician		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD.		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		13e. STREET ADDRESS Rt. 6 Box 628		21801	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 082-10-5734		17. INFORMANT ADDRESS Mr. Ralph Kaufman Rt. 6 Box 628 Salisbury, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1579 CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF: (b) 8 hrs. HYPOTENSION AND ACIDOSIS DUE TO, OR AS A CONSEQUENCE OF: (c) 14 hrs. SEPSIS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0							
19a. DATE OF OPERATION 8/8/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PANCREATIC CARCINOMA		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8-6, 19 83, to 8-2, 19 83, that (I) (we) last saw the deceased alive on 8/2/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John A. Barckovich MD				22c. DATE SIGNED 9-3-83		22d. ADDRESS PO Box 628 Rd. Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/4/83		23c. NAME OF CEMETERY OR CREMATORY Beth-El Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Paramus New Jersey	
24. FUNERAL DIRECTOR NAME ADDRESS Holloway Funeral Home P.A. Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR SEP 7 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

Without

Salisbury Terminal General Hospital



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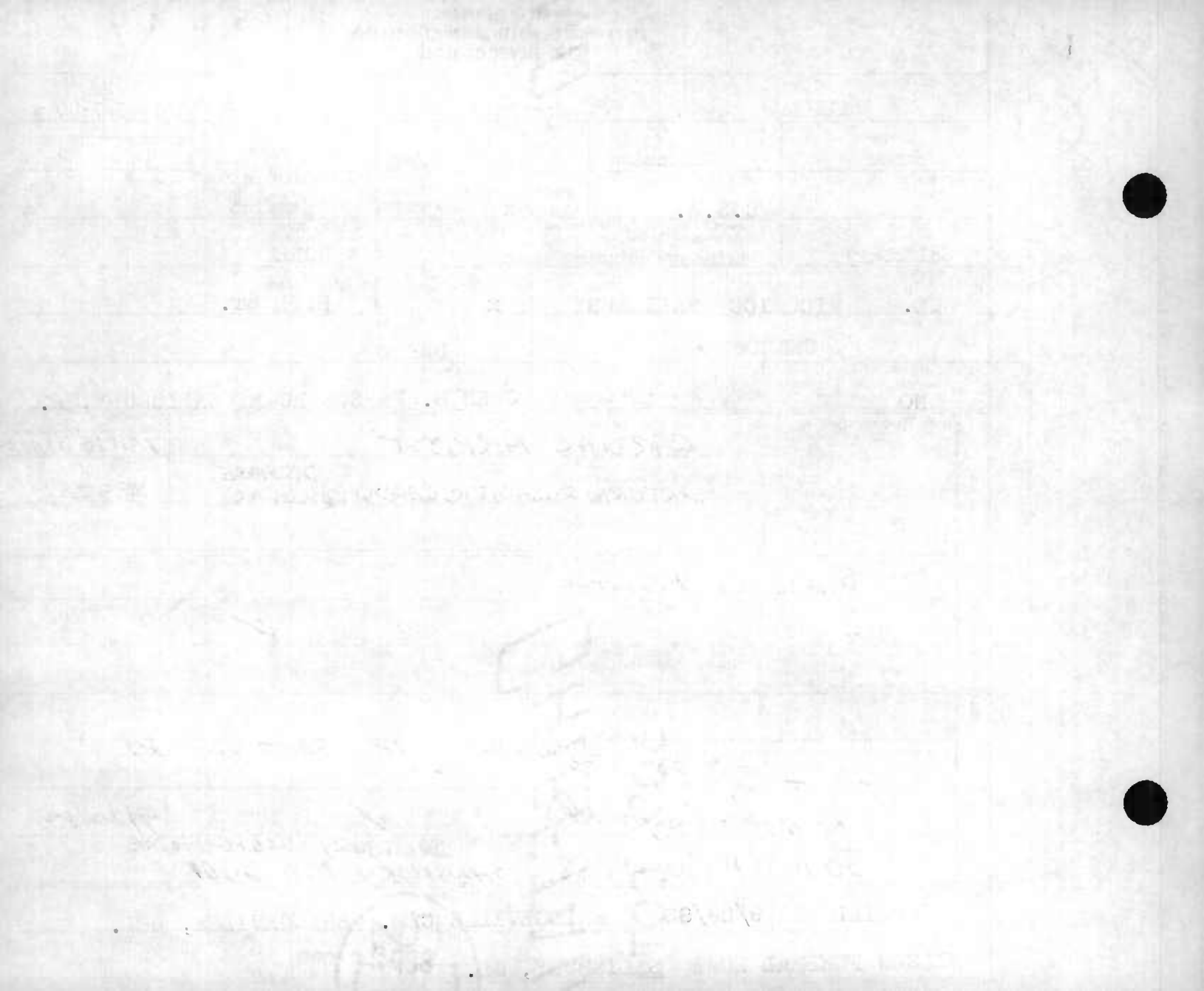
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Lillian W. Hastings					2a. DATE OF DEATH MONTH DAY YEAR 9 22 1983 2b. HOUR 7:00 p.m.					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 5 24 1898		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD.					13b. COUNTY WICOMICO		13c. CITY OR TOWN SALISBURY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 221-05-3918		17. INFORMANT ADDRESS JOHN B. PARSOS HOME SALISBURY, MD.					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST 4292 } APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE YEARS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES MELLITUS</u>										
19a. DATE OF OPERATION NA			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 16</u> , 19 <u>78</u> , to <u>SEPT. 22</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>SEPT. 22</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) view the body after death.										
22b. SIGNATURE <u>John M. Buchness</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/22/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN M. BUCHNESS			22e. ADDRESS SALISBURY NURSING HOME SALISBURY, MD 21801							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9/26/83		23c. NAME OF CEMETERY OR CREMATORY BRIDGEVILLE CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BRIDGEVILLE, DEL.			
24. FUNERAL DIRECTOR NAME WILSON FUNERAL HOME					ADDRESS SALISBURY, MD.		25a. DATE REC'D. BY REGISTRAR SEP 26 1983			
					25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>					



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>George Wixner Hearn</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 2, 1983</b>			2b. HOUR <b>6306 M</b>					
3. SEX <b>Mal</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3-14-1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.					
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOS OF WORKING LIFE) <b>MD State Asst Employee</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Wicomico</b> 13c. CITY OR TOWN <b>Tyaskin</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt 1 Box 124</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest Hearn</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maxy Moore</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>YES</b> 16b. SOCIAL SECURITY NO. (YES, GIVE WAR OR DATES) <b>WW II 213-18-5187</b>				17. INFORMANT ADDRESS <b>Maxy Hearn, Tyaskin, MD</b>							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**CARDIOPULMONARY FAILURE**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**3 hrs.**

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Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Post-Op Pancreatic Resection****hours**

DUE TO, OR AS A CONSEQUENCE OF

(c) **CANCER OF PANCREAS****weeks**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <b>9-1-83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PANCREATIC CARCINOMA</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/30</b> , 19 <b>83</b> , to <b>9/2</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>9/2/83</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John Bartkovic</b> MD				DEGREE <b>MD</b>		22c. DATE SIGNED <b>9-2-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN BARTKOVICH</b>				22e. ADDRESS <b>MEDICAL CENTER - PINE BLUFF RD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/4/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Springhill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury, MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>James Bivette, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 7 1983</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mildred V. Helsby			2a. DATE OF DEATH MONTH DAY YEAR Sept. 3 1983			2b. HOUR 1045 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 5 1902		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (PE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md. 13b. COUNTY Somerset 13c. CITY OR TOWN Cristfield					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt 1 Box 301 21817		
14. FATHER'S NAME FIRST MIDDLE LAST Stooten Sterling			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Willie C. Milbourne			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 220-12-0969			17. INFORMANT Dany Helsby Rt 1 Box 301			17. ADDRESS Cristfield Md. 21817			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 0461 Severe cerebral pathology, probable DUE TO, OR AS A CONSEQUENCE OF (b) Jakob-Creutzfeldt-Jakob Disease DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Azotemia, Digitalis intoxication Hyponatremia									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. ALICEDRY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY/TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/25/83 to 9/3/83, that (I) (we) lost saw the deceased alive on 8/25/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE [Signature]					DEGREE		22c. DATE SIGNED		22d. ADDRESS
23a. BURIAL, CREMATION, REMOVAL (DATE) Buried					23b. DATE Sept 6 1983		23c. NAME OF CEMETERY OR CREMATORY Acbery		23d. LOCATION CITY OR TOWN COUNTY STATE Cristfield Somerset Md
24. FUNERAL DIRECTOR [Signature]					25a. DATE REC'D. BY REGISTRAR SEP 9 1983		25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

25531

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Neikesha Ladawn Henry</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 27, 1983</b>			2b. HOUR <b>2210</b> M	
3. SEX <b>FEMALE</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 27 1983</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>3 35</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Worcester</b>		13c. CITY OR TOWN <b>BERLIN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lon Jones</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KAY MARCINA HENRY</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

7650  
IMMEDIATE CAUSE (a) **Immaturity (140gms)**  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Approx 38 hrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>9/27</b> , 19 <b>83</b> , to <b>9/27</b> , 19 <b>83</b> , that (1) (we) lost saw the deceased alive on <b>9/27</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Alfred C. Kolls</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/27/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alfred C. Kolls</b>				22e. ADDRESS <b>Medical Center, Salisbury, MD</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>10-1-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Peninsula General Hospital Medical Center</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury Wicomico md</b>	
24. FUNERAL DIRECTOR NAME <b>Virginia B Layfield</b>				100 E Carroll St Salisbury, Md 21801		25a. DATE REC'D. BY REGISTRAR <b>OCT 6 1983</b>	
				25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Terminale General Hospital

Terminale

Glenn H. Koff

Glenn H. Koff

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF A DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.																																																	
1. DECEASED NAME (TYPE OR PRINT)										FIRST MIDDLE LAST										2a. DATE OF DEATH										2b. HOUR																																																	
GERTRUDE										H. HICKMAN										9-16-83										A																																																	
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (IN YEARS)										7. IF UNDER 1 YR.										7c. DATE PRONOUNCED DEAD										7d. HOUR																			
FEMALE										WHITE										12 14 1903										79																														9-16-83										0835									
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH																																																	
DELAWARE										U.S.A																				Wicomico																																																	
11. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																																																	
Salisbury										Peninsula General Hospital										HOMEMAKER																																																											
13a. STATE										13b. CITY OR TOWN										13c. STREET ADDRESS																																																											
DELAWARE										SUSSEX										FRANKFORD										DUPONT HWY RT. 113										99999																																							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																																					
RALPH										HUDSON										OCIA										ANNA										HUDSON																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS																																																	
NO										222-20-4966										LESTER HUDSON										FRANKFORD, DE																																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																					
PART I DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										Coronary Occlusion										sudden																																																	
4100										DUE TO, OR AS A CONSEQUENCE OF										Arteriosclerotic Cardiovascular Disease										years																																																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last										(b)										DUE TO, OR AS A CONSEQUENCE OF																																																											
(c)																																																																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																																																															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																																																											
																				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																																											
										P.M. 19																																																																					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION																																																											
																				CITY OR TOWN										COUNTY										STATE																																							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										TITLE (SPECIFY)										DATE SIGNED										9-16-83																																																	
ACTUAL SIGNATURE										M.D. Deputy										MEDICAL EXAMINER																																																											
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																																																																					
Earl W. Royer, M.D.										409 Camden Ave., Salisbury, Md.																																																																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION																																																	
BURIAL										9/19/83										CAREY'S CEMETERY										FRANKFORD										SUSSEX DE																																							
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																											
Melson Funeral Services, Frankford, De.										SEP 21 1983										John J. Conner																																																											

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U.S. GOVERNMENT PRINTING OFFICE

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edgar Selby Higdon Higdon			2a. DATE OF DEATH MONTH DAY YEAR September 5 1983			2b. HOUR 1215 M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 22, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanical Eng.	
12b. KIND OF BUSINESS OR INDUSTRY BG&E		13a. STREET ADDRESS 37 Tanglewood Rd. 21228					
14. FATHER'S NAME FIRST MIDDLE LAST Eugene Stanislaus Higdon							
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Selby							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Mrs. Mary Higdon Same as # 13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4292

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/25, 19 83, to 9/25, 19 83, that (I) (we) lost saw the deceased alive on 9/25, 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. W. Raffetto				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. W. Raffetto				22e. ADDRESS RGH			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/8/83		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS MacNabb Funeral Home Catonsville, Md.				25a. DATE REC'D. BY REGISTRAR SEP 9 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

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U.S. AIR FORCE

Wichita  
Kansas

California Peninsula General Hospital

San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California

San Francisco, California



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IF REQUESTED BY THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										2 5 5 3 4 REG. NO.	
1- FOR STATE REGISTRAR						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 9-11-83 1708 M					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CAROL A. HOLMBOE						2b. DATE PRONOUNCED DEAD 9-11-83 19 M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 29 1941		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND				13b. CITY OR TOWN MONTGOMERY		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3616 PATRICK HENRY DRIVE 20832			
14. FATHER'S NAME FIRST MIDDLE LAST WILLARD E. TILLOTSON						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH WINSLOW					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 130-32-6026		17. INFORMANT ADDRESS MRS. JUDY MARTINETTI, SISTER 236 FELLER DR., CENTRAL ISLIP, NY 11722					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 8161 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 600 P.M. 9-11-83				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Passenger in van, plunged into creek.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) highway				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 50, 1/2 mi. east of Vienna, Wic., Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE [Signature]				M.D. Deputy				MEDICAL EXAMINER DATE SIGNED 9-12-83			
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 9/16/83		23c. NAME OF CEMETERY OR CREMATORY LOCUST VALLEY CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE LOCUST VALLEY NEW YORK	
24. FUNERAL DIRECTOR NAME ADDRESS Holloway Funeral Home, Salisbury, Md.						25a. DATE REC'D. BY REGISTRAR SEP 16 1983		25b. REGISTRAR'S SIGNATURE [Signature]			



RECEIVED 12 22 1941

U.S.A.

RECEIVED 12 22 1941

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RECEIVED 12 22 1941



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMIE ELIZABETH HOLMBOE</b>						2a. DATE KNOWN OF DEATH MONTH DAY YEAR <input checked="" type="checkbox"/> 9-11-83		2b. HOUR 1708			
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>05 31 1971</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>12 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>9-11-83</b>		7d. HOUR <b>11</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>					
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STUDENT</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>OLNEY</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3616 PATRICK HENRY DRIVE</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>ERNEST HOLMBOE</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CAROL ANN TILLOTSON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>213-92-8002</b>		17. INFORMANT ADDRESS <b>MRS. JUDY MARTINETTI, AUNT 236 FELLER DR., CENTRAL ISLIP, NY 11722</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>8161</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1600 9-11-83</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Passenger in van, plunged into creek.</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>highway</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt. 50, 1/2 mi. east of Vienna, Wic., Md.</b>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Earl L. Royer</i>			TITLE (SPECIFY) <b>Deputy</b>			M.D.		DATE SIGNED <b>9-12-83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Earl L. Royer, M.D.</b>			ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9/16/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOCUST VALLEY CEMETERY</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>LOCUST VALLEY, NEW YORK</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>HOLLOWAY FUNERAL HOME SALISBURY, MARYLAND</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 16 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>			



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 25536	
1. DECEASED NAME (TYPE OR PRINT) <b>LEIGH MEGAN HOLMBOE</b>						2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR ESTIMATED <input type="checkbox"/> <b>9-11-83</b>		2b. HOUR <b>1712</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>07 28 1969</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>14</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>9-11-83</b>	
7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.			
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Olney</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest Holmboe</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carol Ann Tillotson</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>213-92-8040</b>				17. INFORMANT <b>Mrs. Judy Martinetti, Aunt</b>				17. ADDRESS <b>236 Feller Drive, Central Islip, NY 11722</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>8161 Drowning</b> IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>1600 P.M. 9-11-83</b>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1600 P.M. 9-11-83</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Passenger in van that plunged into creek</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>highway</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rt. 50, 1/2 mi. east of Vienna, Wic., Md.</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Earl L. Royer</i>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>9-12-83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Earl L. Royer, M.D.</b>				ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>9/16/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOCUST VALLEY CEMETERY</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Locust Valley, N.Y.</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 16 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Conish</i>			



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGE 5 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25537

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MARK			MIDDLE CHRISTIAN			LAST HOLMBOE			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH 9			DAY 11			YEAR 83			2b. HOUR 1715		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 09 01 1965		6. AGE (IN YEARS) LAST BIRTHDAY 18 YRS		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9-11-83			19			2d. HOUR 11			M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico								MD.						
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student				12b. KIND OF BUSINESS OR INDUSTRY										
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY				13c. CITY OR TOWN OLNEY				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 3616 PATRICK HENRY DRIVE										
14. FATHER'S NAME FIRST MIDDLE LAST ERNEST HOLMBOE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CAROL ANN TILLOTSON																						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				(IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 220-60-1917				17. INFORMANT MRS. JUDY MARTINETT, AUNT 236 FELLER DR., CENTRAL ISLIP, NY 11722														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 8160 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes																										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.																										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1600 9-11-83 P.M.				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Driver of van that plunged into creek.																		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) highway Rt.				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 50, 1/2 mi. east of Vienna, Wic., Md.																		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																										
ACTUAL SIGNATURE <i>Earl L. Royer</i>				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 9-12-83														
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.				ADDRESS 409 Camden Ave., Salisbury, Md.																						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 9/16/83				23c. NAME OF CEMETERY OR CREMATORY LOCUST VALLEY CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE LOCUST VALLEY NEW YORK														
24. FUNERAL DIRECTOR NAME Holloway Funeral Home, Salisbury, Md.												25a. DATE REC'D. BY REGISTRAR SEP 16 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>												



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND (21201) PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25538

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>RYAN EDWARD HOLMBOE</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>9</b> DAY <b>11</b> YEAR <b>1983</b>			2b. HOUR <b>1732</b>		
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>11</b> DAY <b>09</b> YEAR <b>1979</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>3</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD <b>9-11-83</b>		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STUDENT</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>OLNEY</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <b>ERNEST</b> MIDDLE <b>HOLMBOE</b> LAST <b>HOLMBOE</b>				15. MOTHER'S MAIDEN NAME FIRST <b>CAROL</b> MIDDLE <b>ANN</b> LAST <b>TILLOTSON</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>1</b>		17. INFORMANT ADDRESS <b>MRS. JUDY MARTINETTI, AUNT</b> <b>236 FELLER DR., CENTRAL ISLIP, NY 11722</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> 8161 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. <b>1600</b> MONTH <b>9</b> DAY <b>11</b> YEAR <b>83</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Passenger in van, plunged into creek.</b>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.) <b>highway</b>		21f. LOCATION STREET <b>Rt. 50, 1/2 mi. east of Vienna, Wic., Md.</b> CITY OR TOWN <b>Wic.</b> COUNTY <b>Wic.</b> STATE <b>Md.</b>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Earl L. Royer</i>		M.D. <b>Deputy</b> MEDICAL EXAMINER				DATE SIGNED <b>9-12-83</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Earl L. Royer, M.D.</b>		ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9/16/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOCUST VALLEY CEMETERY</b>		23d. LOCATION CITY OR TOWN <b>LOCUST VALLEY</b> COUNTY <b>NEW YORK</b> STATE <b>NEW YORK</b>		
24. FUNERAL DIRECTOR <b>HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND</b>				25a. DATE RECD. BY REGISTRAR <b>SEP 16 1983</b> REGISTRAR'S SIGNATURE <i>John J. Conner</i>				





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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. RETAIN PAGE 4 FOR YOUR FILES. PAGE 5 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND (21201) PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25539

REG. NO.

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE PRONOUNCED DEAD		2d. HOUR	
SCOTT FORBES HOLMBOE		9-11-83 1715		1	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
MALE	WHITE	11 19 1974	8	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
MARYLAND		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Salisbury		Peninsula General Hospital		STUDENT	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MARYLAND		MONTGOMERY		OLNEY	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
ERNEST HOLMBOE		CAROL ANN TILLOTSON		NO	
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
213-92-8016		236 FELLER DR., CENTRAL ISLIP, NY 11722		PART 1 DEATH WAS CAUSED BY: Drowning	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				minutes	
20. AUTOPSY?		21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1600 9-11-83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		highway		Rt. 50, 1/2 mi. east of Vienna, Wic., Md.	
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Earl L. Moyer, M.D.		Deputy		9-12-83	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	
Earl L. Moyer, M.D.		409 Camden Ave., Salisbury, Md.		BURIAL	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
9/16/83		LOCUST VALLEY CEMETERY		LOCUST VALLEY	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND		SEP 16 1983		John J. Carver	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Dorothy Virginia Harner</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>SEPTEMBER 4 1983</i>			2b. HOUR <i>1050 M</i>			
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>MAR 15, 1914</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i>		7. UNDER 1 YEAR MONTHS DAYS <i>YRS.</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> MD.			
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR WIFE OR WORKING LIFE) <i>Ref Clerk</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Insurance Adj</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Wicomico</i>		13c. CITY OR TOWN <i>Salisbury</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>103 WALNUT ST</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Richard T. Doody</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie Layman</i>		16. SOCIAL SECURITY NO. <i>214-16-4585</i>		17. INFORMANT ADDRESS <i>Lucille Doody, 103 WALNUT ST, Salisbury Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>3940 Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>malignant lymphoma</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>malignant lymphoma</i>									
19a. DATE OF OPERATION		19b. REASON FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>9/22/83</i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <i>9/22/83</i> 19 <i>83</i> to <i>9/4/83</i> 19 <i>83</i> , that (2) we lost <i>9/4</i> the deceased alive on <i>9/4</i> 19 <i>83</i> , and that in our (our) opinion death occurred on the date and hour and from the causes stated above. (If true, (did) (did not) view the body after death.									
22b. SIGNATURE <i>Chayler Raab MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Chayler Raab MD</i>		22e. ADDRESS <i>PO Box 2636 Salisbury MD 21860</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>9/27/1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Episcopal Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Princess Anne Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Baker &amp; Bouds</i>		ADDRESS <i>Salisbury Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 8 1983</i>		25b. REGISTRAR'S SIGNATURE <i>J. J. Carver</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>BERTHA M. HUDSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 12 1983</b>		2b. HOUR <b>0940</b> M	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 7, 1892</b>		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SEAMSTRESS</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>				
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>WORCESTER</b>		13c. CITY OR TOWN <b>SHOWELL</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>DANIEL J. CATHELL</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE PLUMMER</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>144-10-6722</b>		17. INFORMANT ADDRESS <b>REBECCA L. CATHELL, SHOWELL, MD</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral herniation</b> <b>2396</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>brain tumor</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 days</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **seizures**

19a. DATE OF OPERATION <b>none</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from **9/9**, 19 **83**, to **9/12**, 19 **83**, that (I) (we) lost saw the deceased alive on **9/11**, 19 **83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22a. SIGNATURE <b>Peter R. Sebastian</b>		DEGREE <b>D.O.</b>		22c. DATE SIGNED <b>9/12/83</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER R. SEBASTIAN D.O.</b>		22e. ADDRESS <b>233 FLORIDA AVE. SALISBURY</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>9-14-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SILOAM CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>VINELAND, CUMBERLAND N. J.</b>	
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24. FUNERAL DIRECTOR NAME <b>Charles W. Harts</b> ADDRESS <b>Salisbury, DE</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page(s) may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

25342

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Wesley P. INSLEY, JR.			2a. DATE OF DEATH MONTH DAY YEAR 9-7-83		2b. HOUR 3:40 AM
3. SEX MALE	4. RACE CAU.	5. DATE OF BIRTH MONTH DAY YEAR JULY 10, 1898	6. AGE (IN YEARS LAST BIRTHDAY) 85 yrs. YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO COUNTY MD.		
10. CITY OR TOWN OF DEATH SALISBURY, MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waterman(retired)		12b. KIND OF BUSINESS OR INDUSTRY shellfish
13a. STATE MARYLAND	13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Rt. 50 21801	
14. FATHER'S NAME FIRST MIDDLE LAST WESLEY P. INSLEY, SR.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADELLA STEWART		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-12-1572		17. INFORMANT (son) ADDRESS Md. 21613 Rudolph Insley, 415 Bayly Ave., Cambridge,	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4340

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) generalized arterio sclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/6/83 to 9-7-83, that (I) (we) last saw the deceased alive on 9/6/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.			
22b. SOCIAL SECURITY NO.	DEGREE	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. BEARDSLEY, M.D.	22e. ADDRESS CIVIC AVE., RT. 50, SALISBURY, MD.	22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22g. DATE SIGNED 9/7/83

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE Sept. 9, 1983	23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Pk. Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Airey, Cambridge, Dorchester, Md.
24. FUNERAL DIRECTOR NAME ADDRESS CURRAN FUNERAL HOME, 308 High St., Cambridge, Md. 21613		25a. DATE REC'D. BY REGISTRAR SEP 13 1983	25b. REGISTRAR'S SIGNATURE John J. Conner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NO 130-12-1272  
 WESTLEY, R. E.  
 TINSLEY, JR.  
 (son)  
 ROSEMARY TINSLEY, 415 Holly Ave., Cambridge,  
 MA. 02142  
 STEWART

MARYLAND  
 Wicomico Salisbury

waterman (retired) shellfish

MARYLAND

DATE

JULY 10, 1996

82 yrs.

JR.

CORAN FUNERAL HOME, 505 High St., Cambridge, MA. 02142  
 Sept. 9, 1983 Rochester, N.Y. Co. Army, Cambridge, Rochester,  
 N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										25543			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>CALVIN BUGHDALE James</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>9 5 83</b>				2b. HOUR <b>4:00 AM</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUC.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 16, 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>DELAWARE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.							
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ENGRAVER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>JEWELRY</b>				
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>WISC.</b>		13c. CITY OR TOWN <b>SALISBURY</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>APT. 2D 21801 108 ADAMS STREET</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>EDWIN LEE JAMES SR.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELIZABETH ANN LORR JAMES</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>U.S.A. 222-13-3270</b>		17. INFORMANT APT. 2D ADDRESS 108 ADAMS ST. <b>BRENDA JOYCE HARRIS JAMES SALISBURY, MD.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Coronary Artery Disease</b> DOUE TO, OR AS A CONSEQUENCE OF (c) <b>ZOYOUS</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Cerebrovascular accident; emphysema.</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <b>8.30</b> 19 <b>83</b> to <b>9.5</b> 19 <b>83</b> , that (1) we last saw the deceased alive on <b>9.5</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. He (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Roger C. Merrill M.D.</b>						DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9583</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROGER C. MERRILL M.D.</b>						22e. ADDRESS <b>SALISBURY MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>SEPT 7, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ODD FELLOWS CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SEAFORD SUSSEX DELAWARE</b>					
24. FUNERAL DIRECTOR NAME <b>PAYNTER M. WATSON</b>						ADDRESS <b>SEAFORD, DELAWARE</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 13 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			

BP



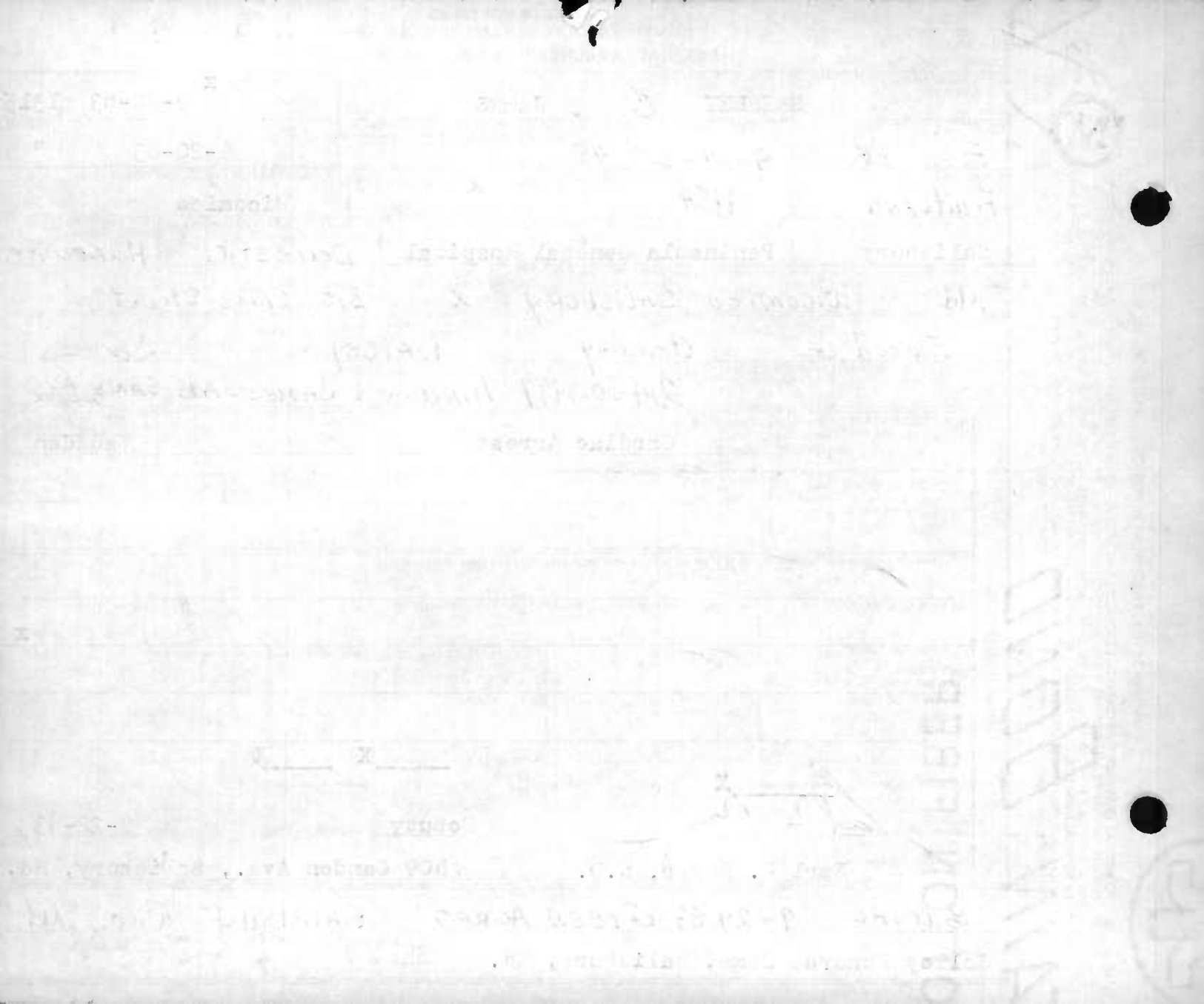
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 25544	
1- FOR STATE REGISTRAR										7a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) <b>SHIRLEY C. JAMES</b>										2b. HOUR <b>1315</b>	
3. SEX <b>F</b> 4. RACE <b>BLK</b> 5. DATE OF BIRTH <b>9-14-35</b> 6. AGE (IN YEARS) <b>48</b> YRS. 7c. DATE PRONOUNCED DEAD <b>9-20-83</b> 19										2d. HOUR <b>"</b> M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Fruitland</b> 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.											
10. CITY OR TOWN OF DEATH <b>Salisbury</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>											
13a. STATE <b>Md.</b> 13b. COUNTY <b>Wicomico</b> 13c. CITY OR TOWN <b>Salisbury</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>512 Collins Street</b> 21801											
14. FATHER'S NAME <b>Elwood G. CONWAY</b> 15. MOTHER'S MAIDEN NAME <b>Daisey JONES</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) 16b. SOCIAL SECURITY NO. <b>214-30-9497</b> 17. INFORMANT <b>LINWOOD JAMES - Add. SAME AS ABOVE</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Cardiac Arrest</b> 4275 IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiac Arrest</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Earl L. Royer</b> M.D. <b>Deputy</b> MEDICAL EXAMINER DATE SIGNED <b>9-22-83</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>Earl L. Royer, M.D.</b> ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b> 23b. DATE <b>9-24-83</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Green Acres</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury Wicomico Md.</b>											
24. FUNERAL DIRECTOR NAME <b>Jolley Funeral Home, Salisbury, Md.</b> ADDRESS 25a. DATE REC'D BY REGISTRAR <b>SEP 29 1983</b> REGISTRAR SIGNATURE <b>John J. Jolley</b>											





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR										2. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 26. HOUR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sharon Maretha Jones										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 26. HOUR									
3. SEX F		4. RACE A A		5. DATE OF BIRTH 3 24 1955		6. AGE (IN YEARS) 28		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 9 3 1983		24. HOUR 4:20		24. HOUR a. M					
7b. BIRTHPLACE (STATE OR FOREIGN) MD.				7c. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County, MD.							
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer				12b. KIND OF BUSINESS OR INDUSTRY Poultry							
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY Md				13c. CITY OR TOWN Somerset				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS Rt. 3 Box 327 D Pr Anne Md							
14. FATHER'S NAME FIRST MIDDLE LAST Louis Elwood Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Juanita Bailey				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. 214-68-6133							
17. INFORMANT				17. INFORMANT ADDRESS Juanita Bailey Rt 3 Box 327 D Pr Anne Md				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY:				IMMEDIATE CAUSE (a) Stab Wound of Chest				DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				(b)				DUE TO, OR AS A CONSEQUENCE OF											
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3 30 xxx 9 3 1983				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was stabbed											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Kings Creek Trailer Park, Princess Anne, Somerset Co., Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 9-4-83											
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE 9/10/83				23c. NAME OF CEMETERY OR CREMATORY Grace United Meth. Ventr				23d. LOCATION CITY OR TOWN COUNTY STATE S.M. Md							
24. FUNERAL DIRECTOR NAME Addie James				ADDRESS 407 Sam. Ave. Pr Anne Md				25a. DATE REC'D. BY REGISTRAR SEP 9 1983				25b. REGISTRAR'S SIGNATURE Joan J. Caruth							



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2nd Lt. A. R. R. 2

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

25546

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST ANNA	MIDDLE MAE	LAST KELLY	2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 13 1983		2b. HOUR 2210 <sup>M</sup>		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 26 1924		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY WICOMICO		13c. CITY OR TOWN SALISBURY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 805 E. CHURCH STREET	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES DAVID				15. MOTHER'S MAIDEN NAME FIRST LAST RUTH SLAUGHTER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-38-0048		17. INFORMANT ADDRESS Mr. William Kelly 805 E. Church Street Salisbury, Md. 21801					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Widely Metastatic Cervical Carcinoma

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (we) hospital attended the deceased from 9/12 to 9/13 1983, that (I) (we) last saw the deceased alive on 9/13 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Joseph A. Grasso MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/14/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grasso		22e. ADDRESS 1300 S. Division St Salisbury					

23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE 9/15/83		23c. NAME OF CEMETERY OR CREMATORY DELMARVA CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE LEWES SUSSEX DELA.	
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, P.A. SALISBURY, MD.				25a. DATE RECD. BY REG. CLERK SEP 22 1983			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND

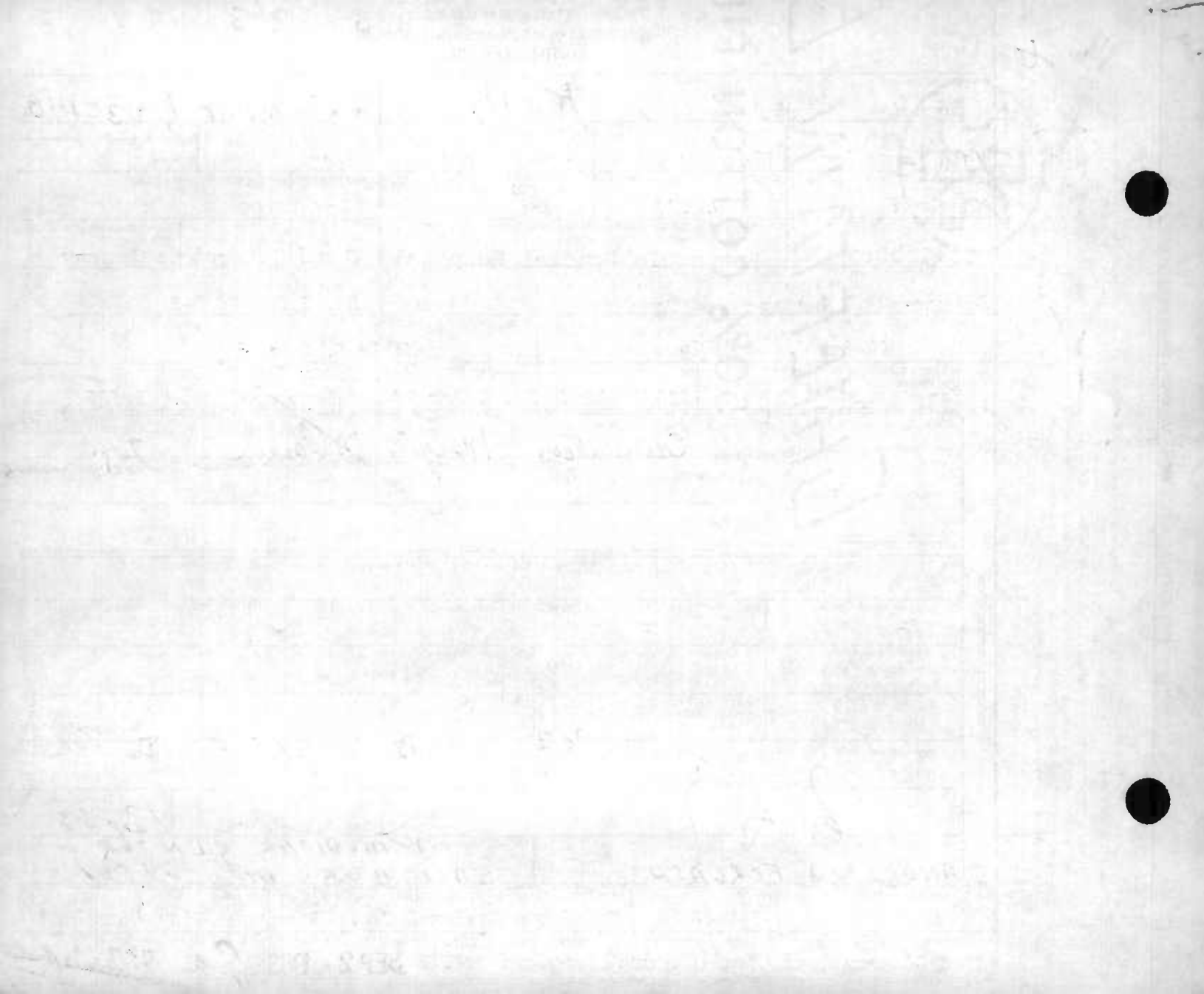
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Francis Joseph Kelly</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 1, 1983 0140</b>		
3. SEX <b>male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 7, 1921</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>C and P Telephone Company</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Delaware</b>	13b. COUNTY <b>Sussex</b>	13c. CITY OR TOWN <b>Dagsboro</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William J. Kelly</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mable L. Krauff</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 11 215-18-3944</b>		17. INFORMANT NAME ADDRESS <b>Mrs. Betty E. Kelly Rt. 1 Box 76 B-1 Dagsboro, Del. 19939</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Malignant Neoplasm</b> <b>1729</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 w</b>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION <b>8</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>8</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>309</b> to <b>1 Sep 83</b> that (I) (we) last saw the deceased alive on <b>31 Aug 83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Andrew J. Forgash</b>		DEGREE		22c. DATE SIGNED <b>1 Sep 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANDREW J. FORGASH</b>		22e. ADDRESS <b>7 MEDICAL CENTER SALISBURY MD. 21801</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8-6-83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21153</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 2 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Caspell</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

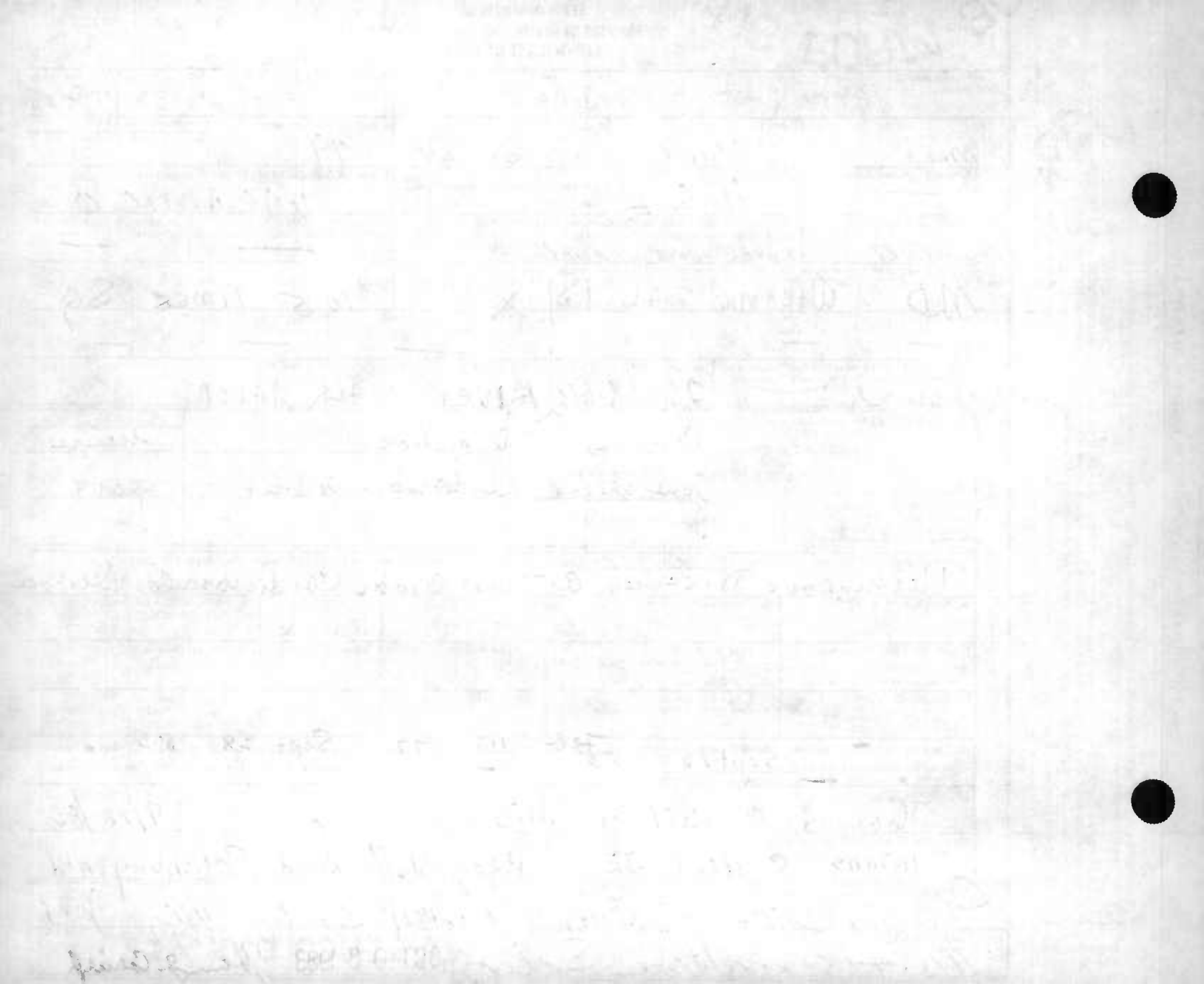
8 3 2 5 5 4 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Vernon</b>			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR <b>Sept. 28 83</b>			2b. HOUR <b>7:45 A.M.</b>		
3. SEX <b>MALE</b>			4. RACE <b>NEGRO</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>05 01 04</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>WILCOMICO MD.</b>		
10. CITY OR TOWN OF DEATH <b>SALISBURY</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>RIVER WALK MANOR</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b>			13b. COUNTY <b>Wilcomico</b>			13c. CITY OR TOWN <b>Salisbury</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. <b>228-68-6102</b>		
17. INFORMANT ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). <b>Cerebral Thrombosis</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>					
19. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last			20. DUE TO, OR AS A CONSEQUENCE OF (b). <b>Generalized Arteriosclerosis</b>			years					
21. DUE TO, OR AS A CONSEQUENCE OF (c).			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Parkinson's Disease, Arteriosclerotic Cardiovascular Disease</b>								
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21f. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21h. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21j. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (if this hospital) attended the deceased from <b>Feb 11 19 77</b> , to <b>Sept 28 19 83</b> , that (we) last saw the deceased alive on <b>Sept 28 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.			22a. SIGNATURE <b>Thomas C Hill Jr.</b>			22b. DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>9/28/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS C. HILL JR</b>			22e. ADDRESS <b>Pine Bluff Road, Salisbury, Md</b>			22f. DATE REC'D. BY REGISTRAR <b>OCT 03 1983</b>			22g. REGISTRAR'S SIGNATURE <b>John J. Carver</b>		
23a. BURIAL, CREMATION, REMOVAL			23b. DATE <b>10-1-83</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury Md Wilcomico</b>		
24. FUNERAL DIRECTOR <b>West Funeral Home</b>			24a. ADDRESS <b>Salisbury</b>			24b. DATE REC'D. BY REGISTRAR <b>OCT 03 1983</b>			24c. REGISTRAR'S SIGNATURE <b>John J. Carver</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 25549			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST GABRIEL ALLEN LAYFIELD				SEPTEMBER 19, 1983			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 02 27 1915		6. AGE (IN YEARS, LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SALISBURY, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD.	
10. CITY OR TOWN OF DEATH SALISBURY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. EMPLOYEE		12b. KIND OF BUSINESS OR INDUSTRY TRUCKING	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE MARYLAND		13b. COUNTY WICOMICO		13c. CITY OR TOWN SALISBURY		13d. STREET ADDRESS ROUTE #5 PEMBERTON DRIVE 21801	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN H. LAYFIELD				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NETTIE C. WEBSTER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-10-8289		17. INFORMANT ADDRESS MRS. MARY Q. LAYFIELD (WIFE) RT #5 PEMBERTON DR., SALISBURY, MD. 21801			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>MASCVD</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>mins.</u> <u>mins.</u> <u>YRS</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Past hx of Angina + hypertension</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>79</u> , to <u>Present</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>5-21-</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Frank Colligan MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/21/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank Colligan, MD.				22e. ADDRESS Riverside Drive, Salisbury, Md. 21801			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/22/1983		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Maryland	
24. FUNERAL DIRECTOR NAME Holloway Funeral Home, P.A. Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR SEP 26 1983		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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Office of the Secretary

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Stephen Albert Lerda			2a. DATE OF DEATH MONTH DAY YEAR September 23 1983		2b. HOUR 1730 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 4 1902		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Glen Lyon, Pa.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Principal	12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Maryland			13b. COUNTY Carroll	13c. CITY OR TOWN Westminster	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Louis Carroll Westminister			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marietta Delagona		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 193-11-8747		17. INFORMANT ADDRESS Arline K. Lerda 22 Westmoreland St. Westminster, Md. 21157	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

4140 IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) Atherosclerotic heart disease and

DUE TO, OR AS A CONSEQUENCE OF

(c) Congestive heart failure

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (the hospital) attended the deceased from 9/23 1983 to 9/23 1983, that (2) (the) last saw the deceased alive on 9/23 1983, and that in my (own) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.			
22b. SIGNATURE C.L. Raab M.D.	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/23/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.L. Raab M.D.		22e. ADDRESS PO Box 2036 Salisbury MD 21801	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9-27-83	23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens	23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg Carroll Md.
24. FUNERAL DIRECTOR NAME Dale Fletcher		25. DATE REC'D. BY REGISTRAR 254 East Main St. Westminster, Md. 21157	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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*[Faint, illegible handwriting on lined paper]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2. DATE OF DEATH				3. REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH				2b. HOUR			
Sarah Olive Long		September 26, 1983				M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		Nov. 3, 1899		83		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland Somerset		U.S.				Wicomico MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		229 W. College Ave.				Housewife			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>		21801 1219 S. Division St.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					
James H. Smullen		Priscilla Dykes		No					
16a. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1929 DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS (c) DUE TO, OR AS A CONSEQUENCE OF CARCINOMA - EPIDERMOID					
219-14-4938		Donald D. Long		229 W. College Ave. Salisbury, Md.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: COLO- VESICAL FISTULA									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
5/18/83		EPIDERMAL CARCINOMA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/18/83, 1983, to 9/26/83, 1983, that (I) (we) lost saw the deceased alive on 9/20/83, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		9/28/83		Beechwood		Princess Anne; Somerset, Md.			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
James L. Hixman		Princess Anne, Md.		OCT 03 1983		James L. Hixman			

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130. Anna Pearson



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (5))  
20M 4/82

Item #5, G-583, 9/22/83 F.H. / Gb STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										25552	
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH	
FIRST MIDDLE LAST ELSIE M. LOWE										2b. HOUR 1112	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12-16-05	6. AGE (IN YEARS) (LAST BIRTHDAY) 78 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD 9-11-83	7d. HOUR 11					
7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7f. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD	13b. COUNTY WIC	13c. CITY OR TOWN SHARPTOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS PARK AVE 21861							
14. FATHER'S NAME FIRST MIDDLE LAST JOSUA J. MORRIS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADDIE MAE ADAMS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 212-05-3747		17. INFORMANT ADDRESS D. VANDERWENDE BELMAR, MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER			DATE SIGNED 9-12-83		
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Hoyer, M.D.			ADDRESS 409 Camden Ave., Salisbury, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9-14-83		23c. NAME OF CEMETERY OR CREMATORY FIREMEN'S			23d. LOCATION CITY OR TOWN COUNTY STATE SHARPTOWN WIC MD.			
24. FUNERAL DIRECTOR NAME Ulrich Funeral Home, Sharptown, Md.						25a. DATE REC'D. BY REGISTRAR SEP 15 1983		25b. REGISTRAR'S SIGNATURE 			



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U.S. AIR FORCE

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FROM: [illegible]  
SUBJECT: [illegible]  
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ENCOUNTERED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (5))  
20M 4/82

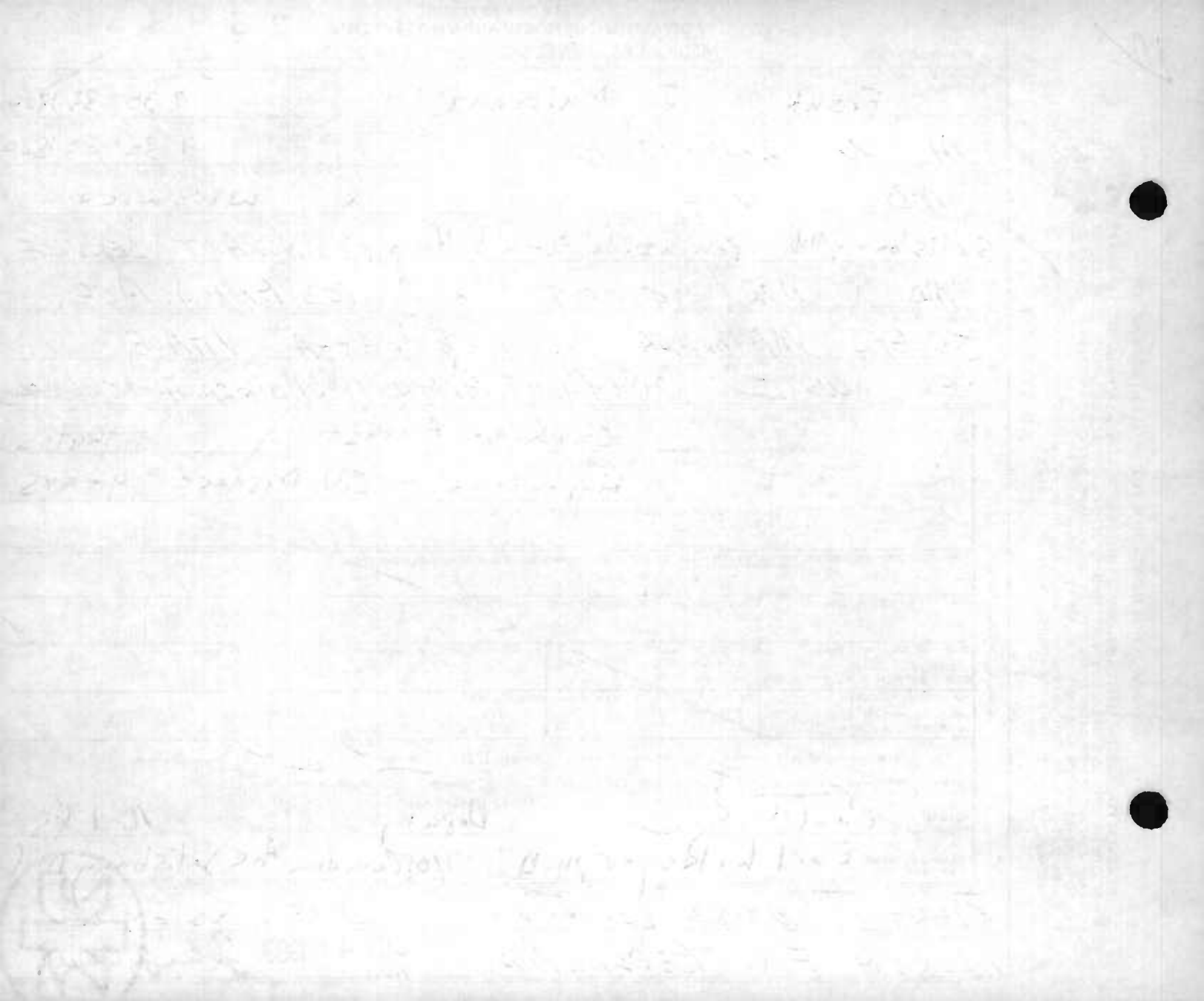
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25553

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Frank			MIDDLE J.			LAST MAIORANA			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH 9			DAY 30			YEAR 1983			2b. HOUR 1820		
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 2-23-13		6. AGE (IN YEARS) LAST BIRTHDAY 70 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR 9 30 1983			2d. HOUR 1820								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD														
10. CITY OR TOWN OF DEATH Salisbury				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula Gen'l Hosp								12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORK DONE) RESTAURANT				12b. KIND OF BUSINESS OR INDUSTRY SERVICE										
13a. STATE MD				13b. COUNTY Wor.				13c. CITY OR TOWN O. CITY				13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1803 PHILA. AVE.												
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH MAIORANA								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CONCETTA VITALE																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 218-09-1047				17. INFORMANT ADDRESS ANTHONY MAIORANA - NEW CREAM																		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Cardiac Arrest Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Hypertensive C.V. Disease (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years																										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																										
ACTUAL SIGNATURE Earl H. Royer				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 10-1-83														
EXAMINER'S NAME (TYPE OR PRINT) Earl H. Royer, M.D.				ADDRESS 408 Camden Ave. Salisbury Md																						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 10-2-83				23c. NAME OF CEMETERY OR CREMATORY DELMAR VA				23d. LOCATION CITY OR TOWN COUNTY STATE LEWES SUSSEX, DEL.														
24. FUNERAL DIRECTOR NAME WILLRICH F.W.								ADDRESS BERLIN, MD.				25a. DATE REC'D BY REGISTRAR OCT 4 - 1983				25b. REGISTRAR'S SIGNATURE John J. Conner										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				25554			
1. DECEASED NAME (TYPE OR PRINT) MITCHELL K. MAIORANA				2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
MITCHELL K. MAIORANA				SEPT. 28, 1983		1539 M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
				01 31 1939		44 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE, MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CO-OWNER RESTAURANT		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND				13b. COUNTY WORCESTER		13c. CITY OR TOWN OCEAN CITY	
14. FATHER'S NAME FIRST MIDDLE LAST SALVATORE MAIORANA				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VERA ADKINS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 216-26-7720		17. INFORMANT ADDRESS Jacqueline Degroft, Sister Ocean City, Md. 21842	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma of COLON DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) DEHYDRATION / INTESTINAL OBSTRUCTION							
19a. DATE OF OPERATION 7/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/28 1983, to 9/18 1983, that (I) (we) lost saw the deceased alive on 9/28 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) [Signature] J. BARTHOVICH				22e. ADDRESS MEDICAL CENTER, SALIS. MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/2/83		23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BERLIN WORCESTER MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS HOLLOWAY FUNERAL HOME, P.A. SALISBURY, MD.				25a. DATE REC'D BY REGISTRAR OCT 3 1983		25b. REGISTRAR'S SIGNATURE [Signature]	

BP

HOLWAY FUNERAL HOME, 100 S. SULLIVAN, NO.

BURIAL 1 WAY 1 CREST MONUMENT PARK

DELLA WOLFE IN WYLAND



COLLECTION  
100 S. SULLIVAN, NO.

215-24-7722

Accompanying Detroit, Mich.  
Detroit, Mich. 48201

WORKING

WYLAND MONROE CITY

ROUTE 1 BOX 207

Peninsula General Hospital

20-2075 SULLIVAN

100 S. SULLIVAN, NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 25555				
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>MARY F. Martin</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>September 10 1983</u>				
3. SEX <u>FEMALE</u>					2b. HOUR <u>2150 M</u>				
4. RACE <u>CAUC.</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>09 25 1898</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>84</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS <u></u>		IF UNDER 24 HRS. HOURS MIN. <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MASS.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Wicomico MD.</u>			
10. CITY OR TOWN OF DEATH <u>Salisbury</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Peninsula General Hospital</u>			12a. USUAL OCCUPATION (GIVE WORK FOR MOST OF WORKING LIFE) <u>TEACHER</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>PUB. SCHOOL</u>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN <u>MASS WERKSHIRE ADAMS</u>					13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <u>6 CRANDALL ST.</u>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>WILLIAM GRADY</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>HANNAH O'MALLEY</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>				
		16b. SOCIAL SECURITY NO. <u>033-28-9619</u>		17. INFORMANT ADDRESS <u>JOHN MARTIN, WILLIAMSTOWN, MASS</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Pulmonary Failure</u> 3481 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Respiratory Distress</u> (c) <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Cardiogenic Shock, Acute Pulmonary Hypoxia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/14</u> 19 <u>82</u> to <u>9/10</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>9/14</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>		DEGREE		22c. DATE SIGNED <u>9/10/82</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>F. HIER</u>		22e. ADDRESS <u>PENINSULA GEN. HOSPITAL WICOMICO CO., SALISBURY, MD.</u>							
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>		23b. DATE <u>9-15-83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BELLEVEUE CEM.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>ADAMS MASS.</u>			
24. FUNERAL DIRECTOR NAME <u>EVES-PEARSON F.H.</u>		ADDRESS <u>ARLINGTON, VA</u>		25a. DATE REC'D. BY REGISTRAR <u>SEP 15 1983</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

50% COTTON

DAILEY





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

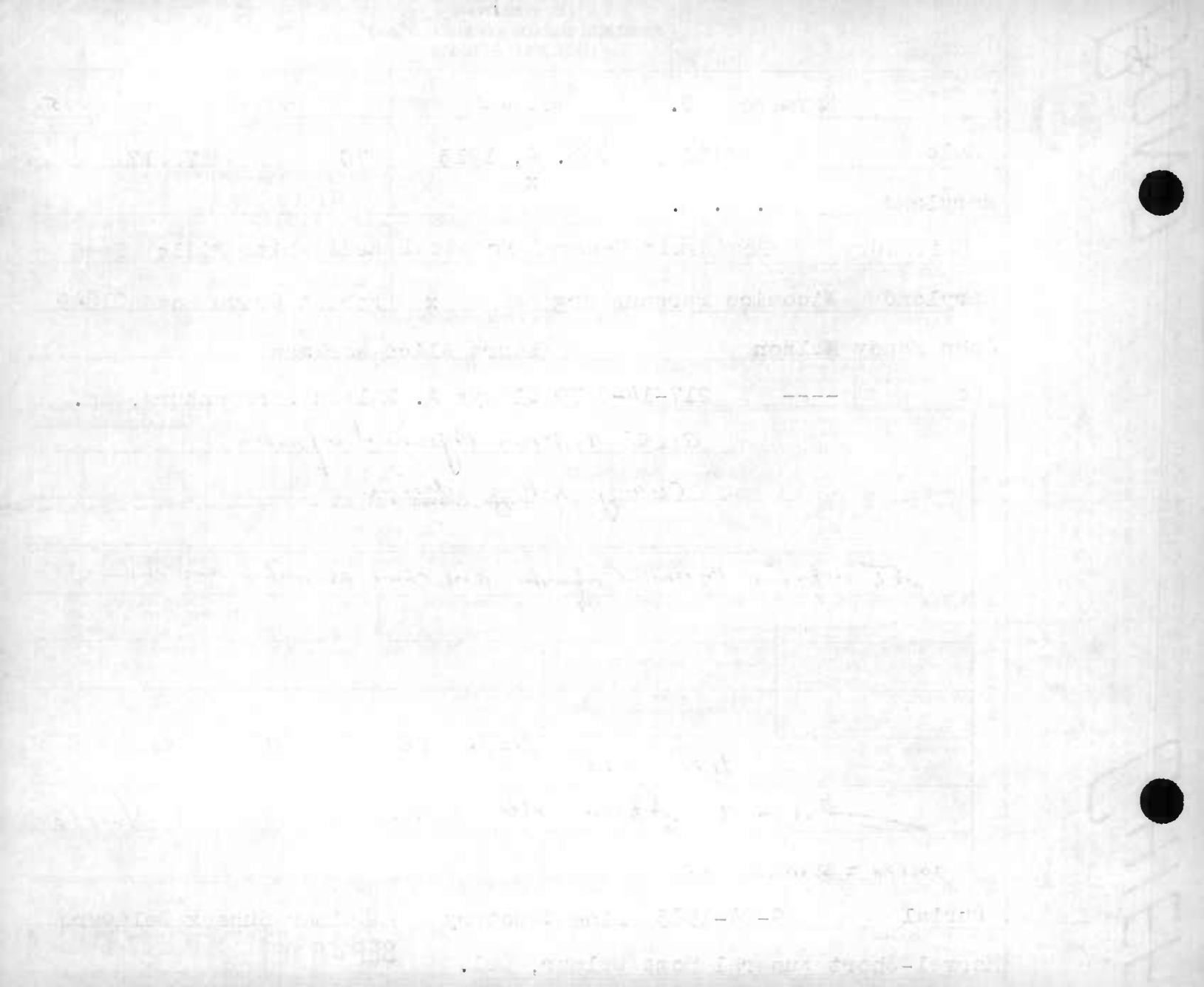
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
Raymond C. MELSON		SEPTEMBER 21, 1983		0835 M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	White	MONTH DAY YEAR	70 YRS.	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U. S. A.		Wicomico MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital		Red & White Mills		Feed
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
Maryland	Wicomico	Parsonsborg	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
John Handy Melson		Laura Alice Workman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		217-14-8879		Gladys A. Melson Parsonsborg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c.)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>acute anterior myocardial infarction</u>					
4100					
DUE TO, OR AS A CONSEQUENCE OF					
(b) <u>coronary artery disease</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (10a)					
<u>old inferior myocardial infarction and chronic obstructive lung disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1/12/82</u> to <u>9/21/83</u> , that (I) (we) lost					
saw the deceased alive on <u>9/21</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Joseph Z. Badros</u>		MD		9/21/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
JOSEPH Z. BADROS MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		9-24-1983		Line Cemetery	
23d. LOCATION		23e. DATE REC'D. BY REGISTRAR			
CITY OR TOWN COUNTY STATE		23f. REGISTRAR'S SIGNATURE			
Delmar Sussex Delaware		SEP 26 1983 <u>John J. Linnell</u>			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR			
NAME ADDRESS		25b. REGISTRAR'S SIGNATURE			
Marvel-Short Funeral Home Delmar, Del.					

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VRA15 ME (5))  
15M 2/80

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25557

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Doris S. MILNER</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>9-10-83</b>			2b. HOUR <b>1710</b>		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 23, 1925</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>9-10-83</b>		7d. HOUR <b>"</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b>		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Citizen's Bank</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles B. Shellman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Charlotte Kurtz</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				
16b. SOCIAL SECURITY NO. <b>578-24-7138</b>		17. INFORMANT ADDRESS <b>4809 67th. Ave. Hyatts. Md.</b> <b>Mr. William A. Milner, Jr.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Earl L. Hoyer</i>		TITLE (SPECIFY) <b>Deputy</b>		M.D. MEDICAL EXAMINER		DATE SIGNED <b>9-12-83</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Earl L. Hoyer, M.D.</b>		ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 14, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>		
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>		

SEP 14 1983

5729 [uncod.]

— — —

1. 4. 1958

1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 26

*Journal of Interpersonal Violence* 26(10)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

James

Allen

NEAL

2a. DATE OF DEATH MONTH DAY YEAR  
September 5, 1983

2b. HOUR

3:45<sup>a</sup><sub>M</sub>

1. SEX

M

4. RACE

B

5. DATE OF BIRTH

MONTH DAY YEAR  
8 27 1912

6. AGE (IN YEARS LAST BIRTHDAY)

71

YRS.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Md

7b. CITIZEN OF WHAT COUNTRY?

U.S.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Wicomico

MD.

10. CITY OR TOWN OF DEATH

Salisbury

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
Deer's Head Center

12a. USUAL OCCUPATION

(TYPE OF WORK OR MOST OF WORKING LIFE)  
Laborer

12b. KIND OF BUSINESS OR INDUSTRY

SEAFOOD

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md

13b. COUNTY

Som

13c. CITY OR TOWN

Crisfield

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

336 Locust St. Crisfield Md.

14. FATHER'S NAME

FIRST MIDDLE LAST  
James H. Neal

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST  
Maud Carter16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

YES

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

2nd W.W.

220-16-4636

17. INFORMANT

ADDRESS

Lucille A. Evans Crisfield, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) end stage renal disease

5860

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

ASCP with CHF, Anemia

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

Nancy W. Tustin, M.D.

ATTENDING PHYSICIAN

MEDICAL DIRECTOR ☒STAFF PHYSICIAN ☐

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Nancy W. Tustin, M.D.

22e. ADDRESS

Deer's Head Center, Salisbury, Md. 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

9/9/83

23c. NAME OF CEMETERY OR CREMATORY

MT. PETER

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

25a. DATE REC'D. BY REGISTRAR

SEP 6 1983

25b. REGISTRAR'S SIGNATURE

John J. Gail

24. FUNERAL DIRECTOR

Anthony E. Ward Crisfield Md.

ADDRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Division of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

107

20% COTTON  
CHIEFLIN



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES F. Oakley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 16, 1983</b>		2b. HOUR <b>0500M</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11-27-33</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.S.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FOREMAN</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>POULTRY</b>	
13a. STATE <b>MD</b>			13b. COUNTY <b>WOR</b>	13c. CITY OR TOWN <b>O.CITY</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES F. OAKLEY, Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DOROTHY CAPEWELL</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>1954</b>		
17. INFORMANT ADDRESS <b>S. TINGLE OCEAN CITY MD.</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4300 IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>  <b>15 years</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b>		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Diabetes Mellitus, Acute Renal Failure.**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9.16</b> , 19 <b>83</b> , to <b>9.16</b> , 19 <b>83</b> , that (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.			
22b. SIGNATURE <b>Kare C. Merrill</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>9/16/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>9-19-83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET M.P.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>BERLIN WOR MD</b>
24. FUNERAL DIRECTOR NAME <b>VLERICH F.H. BERLIN, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 22 1983</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.



Peninsula General Hospital

20% COTTON  
WILKINSON

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Virgil D. Parker			2a. DATE OF DEATH MONTH DAY YEAR September 30, 1983		2b. HOUR 2:50
3. SEX M	4. RACE Blk	5. DATE OF BIRTH MONTH DAY YEAR 9 15 07	6. AGE (IN YEARS LAST BIRTHDAY) 76		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Columbia Del	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD		
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Vault Maker	12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Md		13b. COUNTY Wicomico	13c. CITY OR TOWN Mardela Sp	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Rt #1 Box 394 21837
14. FATHER'S NAME FIRST MIDDLE LAST Levin H. Parker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sara Parker		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 168-09-1292		17. INFORMANT MARY F. PARKER		ADDRESS Add. SAME AS ABOVE	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Chronic Renal failure

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

6 months.

4039

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) Nephrosclerosis

20yrs

DUE TO, OR AS A CONSEQUENCE OF

(c) Hypertension

20yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.

Hypothyroidism

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 9:19 1983, to 9:30 1983, that (I) (we) lost saw the deceased alive on 9:30 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.					
22b. SIGNATURE Sara C. Morrell		DEGREE MD		22c. DATE SIGNED 9/30/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9-6-83	23c. NAME OF CEMETERY OR CREMATORY Zion United	23d. LOCATION CITY OR TOWN COUNTY STATE Sharptown Wico, Md.
24. FUNERAL DIRECTOR NAME Volley Memorial Chapel		25. DATE REC'D. BY REGISTRAR OCT 5 1983	
26. REGISTRAR'S SIGNATURE Sara C. Morrell		27. REGISTRAR'S SIGNATURE	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes on lined paper, including a date "1951-12-14" and various illegible entries.



200

CO



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RAMONA MILDRED PAUL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>September 9, 1983</b>			2b. HOUR <b>0100 M</b>			
3. SEX <b>Female</b>		4. RACE <b>CAU.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 21, 1943</b>		6. AGE IN YEARS LAST BIRTHDAY <b>40</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Data Device Oper.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>govmt. St. of Md.</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>DORCHESTER</b>		13c. CITY OR TOWN <b>GOLDEN HILL</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Box 23, Golden Hill, Md. 21622</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MELVIN PAUL, SR.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FRANCES GOOTEE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Refractory Ventricular Arrhythmia</b> <b>4241</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aortic Valve Disease and</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>16</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>9/8</b> , 19 <b>83</b> , to <b>9/8</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>9/8</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>J.H. Raffetto</b>						DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J.H. Raffetto</b>						22e. ADDRESS <b>G H</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>SEPT. 11, 1983</b>		23c. NAME OF CEMETERY <b>St. John's Church</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Golden Hill, Dorchester, Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Curran Funeral Home, 308 High St., Cambridge, Md. 21613</b>						25a. DATE REC'D. BY REGISTRAR <b>SEP 13 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>	

BP

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1987. 11. 19. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847. 848. 849

Current Enrollment No. 308 High St., Cambridge, Mass. 02138

Golden Hill, Worcester, Mass.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                  |  |  |   |  |   |   |   |   | 25562    |  |
|---|------------------|--|--|---|--|---|---|---|---|----------|--|
| 1. FOR STATE REGISTRAR  |                  |  |  |   |  |   |   |   |   | REG. NO. |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>GOLDEN G. PETERS   |                  |  |  |   |  | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><input checked="" type="checkbox"/> 9-11-83        |   | 2b. HOUR<br>1415  |   |          |  |
| 3. SEX<br>Male  | 4. RACE<br>Black | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7-3-1909   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br>74   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN. |   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>9-11-83 |   | 2d. HOUR<br>11  |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Md   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Wicomico  |   |   |   |          |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Peninsula General Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Lumber                         |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |          |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |                  |  |  |   |  |   |   |   |   |          |  |
| 13a. STATE<br>Md  |                  | 13b. COUNTY<br>Wicomico  |  | 13c. CITY OR TOWN<br>Quantico   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br>RT 1 Five Towers Road  |   |          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Charles Peter   |                  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Martha Gathie                                  |   |   |   |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |                  |  |  | 16b. SOCIAL SECURITY NO.<br>-<br>218-24-2640  |  | 17. INFORMANT<br>ADDRESS<br>Mabel Evans, Mintucke, Md   |   |   |   |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease<br>4029<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                  |  |  |   |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>years |          |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |                  |  |  |   |  |   |   |   |   |          |  |
| 19a. DATE OF OPERATION  |                  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |          |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |   |   |   |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |   |          |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |  |  |   |  |   |   |   |   |          |  |
| ACTUAL SIGNATURE<br><i>Earl L. Royer</i>  |                  |  |  | TITLE (SPECIFY)<br>M.D. Deputy  |  |   |   | DATE SIGNED<br>9-12-83  |   |          |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT) Earl L. Royer, M.D.  |                  |  |  | ADDRESS<br>409 Camden Ave., Salisbury, Md.  |  |   |   |   |   |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial 9/16/83   |                  |  |  | 23b. NAME OF CEMETERY OR CREMATORY<br>Zion Church Cem.  |  |   |   | 23c. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Quantico Md                           |   |          |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Messick Funeral Home, Bivalve, Md.  |                  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 15 1983  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>   |   |   |   |          |  |

MEDICAL CERTIFICATION





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <u>Winterfield S. POLK</u> |  |  | 2a. DATE OF DEATH<br>MONTH <u>9</u> DAY <u>27</u> YEAR <u>83</u> |   |  | 2b. HOUR<br><u>2:47 PM</u>   |  |   |  |
| 3. SEX<br><u>M</u>   |  | 4. RACE<br><u>Blk</u>  |  | 5. DATE OF BIRTH<br>MONTH <u>9</u> DAY <u>30</u> YEAR <u>20</u>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>63</u> YRS.                                  |  |   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><u>ALLEN</u>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Wicomico</u> MD.                        |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><u>Salisbury</u>                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Peninsula General Hospital</u> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Laborer</u> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Retired</u> |  |

|   |  |                                |   |   |  |   |  |  |
|---|--|--------------------------------|---|---|--|---|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  | 13e. STREET ADDRESS<br><u>Rt #1, Box 374 21822</u>                |  |  |
| 13a. STATE<br><u>Md</u>   |  | 13b. COUNTY<br><u>Wicomico</u> |   | 13c. CITY OR TOWN<br><u>Eden</u>  |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST <u>CLARENCE G.</u> MIDDLE <u>POIK</u> LAST <u>POIK</u>       |  |                                |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <u>ROSA</u> MIDDLE <u>JONES</u> LAST <u>JONES</u> |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <u>WW II</u>       |  |                                |   | 16b. SOCIAL SECURITY NO.<br><u>214-16-7596</u>                                      |  | 17. INFORMANT<br>ADDRESS <u>Rt #1 Box 331</u><br><u>Eden, Md.</u> |  |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u><br><u>4360</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

|                        |  |  |  |   |  |  |  |
|------------------------|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
|------------------------|--|--|--|---|--|--|--|

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |

22a. I certify that (I) (this hospital) attended the deceased from 9/27/83 to 9/27/83, that (I) (we) lost saw the deceased alive on 9/27/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

|   |  |        |  |  |  |                                    |  |
|---|--|--------|--|--|--|------------------------------------|--|
| 22b. SIGNATURE<br><u>David E. Cowall MD</u>                           |  | DEGREE |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>9/27/83</u> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>DAVID E. COWALL, M.D.</u> |  |        |  | 22e. ADDRESS<br><u>1300 S. Division St. Salisbury, MD 21801</u>  |  |                                    |  |

|   |  |                              |  |  |  |  |  |
|---|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE OR PRINT) <u>BURIAL</u>                |  | 23b. DATE<br><u>010-1-83</u> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Friendship UM</u> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>ALLEN Wico, Md.</u> |  |
| 24. FUNERAL DIRECTOR<br>NAME <u>Jolley Mem. Chapel - Salisbury, Md.</u> ADDRESS |  |                              |  | 25. DATE REC'D. BY REGISTRAR<br><u>0CT 3 1983</u>          |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Cowell</u>                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

Missouri

Salisbury

Benjamin's General Hospital

100% COI  
1/17/41



Letter from [illegible] to [illegible]  
[illegible] [illegible] [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   | REG. NO.   |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Frank James RICHARDSON   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>Sept. 28, 1983                                   |  |  | 2b. HOUR<br>2:45 AM  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>05 06 1920   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.                                       |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Central Falls, R.I.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Wicomico MD.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Deer's Head Center |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired trucker |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Trucking  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>Rt #3 Box 59 Shell Road |  |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Wicomico  |  | 13c. CITY OR TOWN<br>Delmar   |  |  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>William Richardson  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Margaret J. Holderness  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>WWII 032-09-2593   |  | 17. INFORMANT ADDRESS<br>Mrs.. Sandra R. Jackson, Daughter<br>Route #3 Box 59 Shell Rd., Delmar, Md. 21875  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Schwanoma of the maxillary sinus<br>2120<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Chronic obstructive pulmonary disease<br>years<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1982 |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>        |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/16/83, to 9/28/83, that (I) (we) lost saw the deceased alive on 9/28/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.     |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Inja J. Hwang  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br>9/28/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Inja J. Hwang   |  |  |  | 22e. ADDRESS<br>Deer's Head Center, Salisbury, Md. 21801  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>9/30/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Springhill Memory Gardens   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Hebron Wicomico Md.                   |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Holloway Funeral Home, P.A. Salisbury, Md.  |  |  |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR<br>OCT 3 1983                                      |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conish   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at \_\_\_\_\_

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 25565   |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVELYN Virginia Ring   |  |   |  | September 14 1983 2105 M   |  |   |  |
| 3. SEX Female   |  | 4. RACE White   |  | 5. DATE OF BIRTH MONTH DAY YEAR 7 13 1908  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.   |  |
| 10. CITY OR TOWN OF DEATH Salisbury   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher  |  | 12b. KIND OF BUSINESS OR INDUSTRY Kindergarten  |  |
| 13a. STATE Maryland 13b. COUNTY Wicomico 13c. CITY OR TOWN Fruitland  |  |   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS 106 PARSONAGE ST.   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Webb  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH DUNN   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  |   |  |
| 16b. SOCIAL SECURITY NO. 218-30-2291  |  | 17. INFORMANT Harry Ring  |  | ADDRESS See Sec 13   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4140 Acute Pulm. Edema & Cardiac Arrest<br>DUE TO, OR AS A CONSEQUENCE OF (b) myocardial Infarction<br>DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease         |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes mellitus   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8 6, 19 82, to 9 14, 19 83, that (I) (we) lost saw the deceased alive on 9 14, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE D. Saggan  |  | DEGREE MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED 9/14/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. Saggan   |  | 22e. ADDRESS Salisbury, Maryland 21801  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (IF ANY) BURIAL   |  | 23b. DATE 9-17-1983   |  | 23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem PK   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico MD   |  |
| 24. FUNERAL DIRECTOR BAKER & BOUNDS   |  | ADDRESS Salisbury, Md.  |  | 25a. DATE REC'D. BY REGISTRAR SEP 19 1983  |  | 25b. REGISTRAR'S SIGNATURE  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |   |   |  |   |
|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>MILTON T. Rogers   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>September 13 1983   |  | 2b. HOUR<br>1615 M  |
| 3. SEX<br>MALE  | 4. RACE<br>WHITE  | 5. DATE OF BIRTH MONTH DAY YEAR<br>7 1 1905   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>78 YRS.                  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>DELAWARE   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Peninsula General Hospital |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Wicomico MD. |   |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a. STATE 12b. COUNTY<br>DELAWARE SUSSEX |   | 13a. CITY OR TOWN<br>SELBYVILLE   |  | 13b. STREET ADDRESS<br>RD #2 BOX 21 99999                     |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>WILLIAM ROGERS   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>SALLIE ROGERS   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) NO   |   | 16b. SOCIAL SECURITY NO.<br>222-24-0654   |  | 17. INFORMANT ADDRESS<br>EDNA E. ROGERS RD#2 BOX 21 SALISBURY |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4360 IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Left Pulmonary Haemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

|   |  |  |  |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)<br><u>Cerebrovascular Accident</u>   |  |  |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/13/83</u> 19 <u>83</u> to <u>9/13</u> 19 <u>83</u> that (I) (we) last saw the deceased alive on <u>9/13/83</u> 19 <u>83</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><u>W. J. Jagger</u> MD  | DEGREE   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br>9/13/83  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |

|  |                      |   |  |
|--|----------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL   | 23b. DATE<br>9/16/83 | 23c. NAME OF CEMETERY OR CREMATORY<br>RED MENS CEMETERY | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SELBYVILLE SUSSEX DEL. |
| 24. FUNERAL DIRECTOR<br><u>Doug Melson</u><br>NAME ADDRESS<br>DOUG MELSON THATCHER ST. FRANKFORD |                      | 25a. DATE REC'D. BY REGISTRAR<br>SEP 21 1983            | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Carver</u>                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |                           |  |
|---|--|--|---|---------------------------|--|
| 1. FOR STATE REGISTRAR  |  | 2. DATE OF DEATH   |   | 3. HOUR                   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | 2. DATE OF DEATH   |   | 3. HOUR                   |  |
| FIRST MIDDLE LAST   |  | MONTH DAY YEAR   |   | A. M.                     |  |
| William Earl Roth   |  | September 30, 1983   |   | 7:45 A.                   |  |
| 3. SEX  | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. IF UNDER 1 YEAR        |  |
| Male  | White  | MONTH DAY YEAR   | 65 YRS.   | MONTHS DAYS HOURS MIN.    |  |
| 12 15 1917  |  |  |   |                           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |                           |  |
| Pittsburgh, Pa.   | U.S.A.   |  | Wicomico MD.  |                           |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                           |  |
| Salisbury   | 616 Dover Street   | Driver   | Drycleaning   |                           |  |
| 13a. STATE  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS       |  |
| Maryland  | Wicomico   | Salisbury  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 616 Dover Street 21801    |  |
| 14. FATHER'S NAME   | 15. MOTHER'S MAIDEN NAME   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |   |                           |  |
| FIRST MIDDLE LAST   | FIRST MIDDLE LAST  | No   |   |                           |  |
| Daniel Roth   | Nellie (unknown)   | 16b. SOCIAL SECURITY NO. 427-07-5515A  |   |                           |  |
| 17. INFORMANT   |  | 17. ADDRESS  |   |                           |  |
| Mrs. Eloise E. Roth, Wife   |  | 616 Dover Street Salisbury, Md. 21801  |   |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |                           |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |   |                           |  |
| IMMEDIATE CAUSE (a) 4100 Cardiac arrest due to acute Myocardial infarction due to Coronary artery disease   |  |  |   |                           |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) and hypersthenic & diabetes mellitus   |  |  |   |                           |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |   |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |                           |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                           |  |
|   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |                           |  |
|   | P.M. 19  |  |   |                           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |                           |  |
|   |  |  |   |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 79 to 9/30 19 83, that (I) (we) last saw the deceased alive on 9/30 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |                           |  |
| 22b. SIGNATURE  |  | DEGREE   |   | 22c. DATE SIGNED          |  |
| Joseph Z. Badros  |  | M.D.   |   |                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |   |                           |  |
| Joseph Z. Badros, M.D.  |  | 229 Florida Avenue, Salisbury, Md. 21801   |   |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |                           |  |
| Burial  | 10/4/83  | Jerusalem Church Cemetery  | Parsonburg Wicomico Md.   |                           |  |
| 24. FUNERAL DIRECTOR NAME   |  | 25. DATE REC'D. BY REGISTRAR   |   | 25. REGISTRAR'S SIGNATURE |  |
| Holloway Funeral Home, P.A. Salisbury   |  | OCT 4 - 1983   |   | John J. Casper            |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES  
DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

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|   |   |   |  |  |  |  |                     |                  |     |       |           |  |
|---|---|---|--|--|--|--|---------------------|------------------|-----|-------|-----------|--|
| 1. FOR STATE REGISTRAR  |   | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  | MIDDLE   | LAST   | 2a. DATE OF DEATH   | MONTH            | DAY | YEAR  | 2b. HOUR  |  |
|   |   | Mildred G. ROYER  |  |  |  |  | 9-23-83             |                  |     |       | 8:45 A.M. |  |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR  |                     | IF UNDER 24 HRS. |     |       |           |  |
| Female  | White   | MONTH DAY YEAR<br>02 17 1908  |  | 75   |  | MONTHS DAYS  |                     | HOURS MIN.       |     |       |           |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |  |                     |                  |     |       |           |  |
| Maryland  | U.S.A.  |   |  | Wicomico County  |  |  |                     |                  |     | MD.   |           |  |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                        |  |                     |                  |     |       |           |  |
| Salisbury, Md.  | Salisbury Nursing Home  |   | Housewife  |  |  |  |                     |                  |     |       |           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   | 13a. STATE  |  | 13b. COUNTY  | 13c. CITY OR TOWN  | 13d. INSIDE CITY LIMITS?                                       | 13e. STREET ADDRESS |                  |     |       |           |  |
| Maryland  |   | Wicomico  |  | Fruitland  | YES <input type="checkbox"/> NO <input type="checkbox"/> | 621 S. Camden Avenue   |                     |                  |     | 21826 |           |  |
| 14. FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |                     |                  |     |       |           |  |
| FIRST MIDDLE LAST<br>John S. Murray   |   | FIRST MIDDLE LAST<br>Mae B. Taylor  |  |  |  |  |                     |                  |     |       |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT  |  | ADDRESS  |                     |                  |     |       |           |  |
| No  |   | 217-30-7822   |  | Mae B. Donalds   |  | 621 S. Camden Avenue, Fruitland, Md. 21826                     |                     |                  |     |       |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |   | DUE TO, OR AS A CONSEQUENCE OF  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                |  |  |                     |                  |     |       |           |  |
| 4340  |   | cerebral thrombosis   |  | 1 wk   |  |  |                     |                  |     |       |           |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |   | (b) generalized arterio sclerosis   |  | yrs.   |  |  |                     |                  |     |       |           |  |
|   |   | (c) DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |                     |                  |     |       |           |  |
|   |   | (d)   |  |  |  |  |                     |                  |     |       |           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |   |   |  |  |  |  |                     |                  |     |       |           |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                     |                  |     |       |           |  |
|   |   |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                     |                  |     |       |           |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |                     |                  |     |       |           |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |                     |                  |     |       |           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/6, 1983, to 9/23, 1983, that (I) (we) last saw the deceased alive on 9/22, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) |   | 22b. SIGNATURE<br>Earl M. Beardsley   |  | 22c. DATE SIGNED<br>9/23/83  |  |  |                     |                  |     |       |           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS  |  |  |  |  |                     |                  |     |       |           |  |
| EARL M. BEARDSLEY, M.D.   |   | RT. 50& CIVIC AVE, SALISBURY, MD. 21801   |  |  |  |  |                     |                  |     |       |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |                     |                  |     |       |           |  |
| Burial  |   | 9/27/83   |  | Wicomico Memorial Pk   |  | Salisbury Wicomico Maryland                                    |                     |                  |     |       |           |  |
| 24. FUNERAL DIRECTOR<br>NAME  |   | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |                     |                  |     |       |           |  |
| Holloway Funeral Home, P.A. Salisbury, Md.  |   | SEP 27 1983   |  | John J. Smith  |  |  |                     |                  |     |       |           |  |

The medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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• *Hydrophilus* sp. and *Hydrophilus* sp.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |
|--|--|---|---|
| 1. FOR STATE REGISTRAR   |  | 25569   |   |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |   |
| Mary Margaret Schlichting  |  | September 23 1983   |   |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH MONTH DAY YEAR   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |
| Female   | White  | 1-2-02  | 81 YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |
| Mich.  | U.S.A.   |   | Wicomico MD.  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)       |
| Salisbury  | Peninsula General Hospital   |   | Ret. Postmistress   |
| 13a. STATE   | 13b. COUNTY  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  |
| Florida  | Polk   | Fedhaven  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |   | 13e. STREET ADDRESS / ZIP CODE                                      |
| Joseph Fitzgerald  | Ellen Cornor   |   | P.B.O. 42 Apt. 42   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS   |   |
| No   | 900-13-3536B   | Harold E. Schlichting Same as 13e   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BLADDER CANCER</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |  |   |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |
|  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |
|  | P.M. 19  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |
|  |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/23</u> 19 <u>83</u> , to <u>9/23</u> 19 <u>83</u> , that (I/we) last saw the deceased alive on <u>9/23</u> 19 <u>83</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (not) view the body after death. |  |   |   |
| 22b. SIGNATURE   |  | DEGREE  | 22c. DATE SIGNED  |
| <u>David E. Cowall</u>   |  | MD  | 9/24/85   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |   |
| DAVID E. COWALL, M.D.  |  | 1300 S. Division St Salisbury, MD 21801   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |
| Burial   | 9-28-83  | Port Sanilac Cem  | Port Sanilac MICH.  |
| 24. FUNERAL DIRECTOR NAME ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR   | 25b. REGISTRAR'S SIGNATURE  |
| Holloway Funeral Home Salisbury Md.  |  | SEP 27 1983   | <u>John J. Cowell</u>   |

BP

DHMH - 16 50M / 83  
(VRA 15, 4)





Cor. phone conv. with FH

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

25570

FOR 9-26-83jlb  
1. STATE REGISTRAR

REG. NO.

|  |  |  |   |   |   |  |  |  |  |
|--|--|--|---|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>PAUL FRANCIS Shaffer</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>September 22, 1983</b>                                   |   |   | 2b. HOUR <b>8:10 A</b>   |  |  |  |
| 1. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>white</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>6 17 1921</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>62</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pa.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Wicomico</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Peninsula General Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Truck Driver</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Delaware</b> 13b. COUNTY <b>Sussex</b> 13c. CITY OR TOWN <b>Millsboro</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>Box 112 Rt #4 19966</b>                  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>George Shaffer</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Helen Marie Eroit</b>  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>yes</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>165-18-0713</b>  |   | 17. INFORMANT ADDRESS<br><b>Alice S. Shaffer See Sec 13</b>                   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Brain Stem Hemorrhage</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>72 hrs</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                          |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |  |  |  |
| 22a. certify that (I) (this hospital) attended the deceased from <b>9/20</b> 19 <b>83</b> to <b>9/22</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>9/20</b> 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Daniel W Moore</b>  |  |  | DEGREE  |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9/22</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DANIEL W MOORE</b>   |  |  | 22e. ADDRESS<br><b>PGH MED CENT SALISBURY</b>   |   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |  | 23b. NAME OF CEMETERY OR CREMATORY<br><b>9-24-1983 Highland Mem.</b>                            |   |   | 23c. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Pottstown Monticello MD</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>BAKER &amp; BOUNDS</b>  |  |  | ADDRESS<br><b>Salisbury, Md</b>   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 26 1983</b>  |  |  |  |

MEDICAL CERTIFICATION

LIBRARY

100-100000

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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20036-0001

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BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.  
20036-0001

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Sylvester Elwood SHOCKLEY</b>            |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>September 1, 1983</b> |   |  | 2b. HOUR<br><b>11:40</b> M P  |  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08 21 1917</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Snow Hill, Md.</b>                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Wicomico</b> MD.                                     |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>                                      |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Deer's Head Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Truck Driver</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                               |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Wicomico</b>   |  | 13c. CITY OR TOWN<br><b>Salisbury</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>301 Carrollton Avenue</b> 21801       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Sylvester C. Shockley</b>             |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary B. Butler</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b> |  | 16b. SOCIAL SECURITY NO.<br><b>212-18-6442</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Marie H. Shockley, Wife 21801<br/>301 Carrollton Avenue Salisbury, Maryland</b>   |  |   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1629

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>E.P. Ritchings, M.D.</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9/1/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E.P. Ritchings, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>Deer's Head Center, Salisbury, Md. 21801</b>  |  |   |  |

|   |  |                            |  |   |  |   |  |
|---|--|----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                             |  | 23b. DATE<br><b>9/3/83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wicomico Memorial Pk</b>                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Salisbury Wicomico Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Holloway Funeral Home, P.A. Salisbury, Md.</b> |  |                            |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>SEP 6 1983 John J. Smith</b> |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. *Chrysomelids*, *A. 5*, *1900*, *1901*, *1902*, *1903*, *1904*, *1905*, *1906*, *1907*, *1908*, *1909*, *1910*, *1911*, *1912*, *1913*, *1914*, *1915*, *1916*, *1917*, *1918*, *1919*, *1920*, *1921*, *1922*, *1923*, *1924*, *1925*, *1926*, *1927*, *1928*, *1929*, *1930*, *1931*, *1932*, *1933*, *1934*, *1935*, *1936*, *1937*, *1938*, *1939*, *1940*, *1941*, *1942*, *1943*, *1944*, *1945*, *1946*, *1947*, *1948*, *1949*, *1950*, *1951*, *1952*, *1953*, *1954*, *1955*, *1956*, *1957*, *1958*, *1959*, *1960*, *1961*, *1962*, *1963*, *1964*, *1965*, *1966*, *1967*, *1968*, *1969*, *1970*, *1971*, *1972*, *1973*, *1974*, *1975*, *1976*, *1977*, *1978*, *1979*, *1980*, *1981*, *1982*, *1983*, *1984*, *1985*, *1986*, *1987*, *1988*, *1989*, *1990*, *1991*, *1992*, *1993*, *1994*, *1995*, *1996*, *1997*, *1998*, *1999*, *2000*, *2001*, *2002*, *2003*, *2004*, *2005*, *2006*, *2007*, *2008*, *2009*, *2010*, *2011*, *2012*, *2013*, *2014*, *2015*, *2016*, *2017*, *2018*, *2019*, *2020*, *2021*, *2022*, *2023*, *2024*, *2025*, *2026*, *2027*, *2028*, *2029*, *2030*, *2031*, *2032*, *2033*, *2034*, *2035*, *2036*, *2037*, *2038*, *2039*, *2040*, *2041*, *2042*, *2043*, *2044*, *2045*, *2046*, *2047*, *2048*, *2049*, *2050*, *2051*, *2052*, *2053*, *2054*, *2055*, *2056*, *2057*, *2058*, *2059*, *2060*, *2061*, *2062*, *2063*, *2064*, *2065*, *2066*, *2067*, *2068*, *2069*, *2070*, *2071*, *2072*, *2073*, *2074*, *2075*, *2076*, *2077*, *2078*, *2079*, *2080*, *2081*, *2082*, *2083*, *2084*, *2085*, *2086*, *2087*, *2088*, *2089*, *2090*, *2091*, *2092*, *2093*, *2094*, *2095*, *2096*, *2097*, *2098*, *2099*, *2100*, *2101*, *2102*, *2103*, *2104*, *2105*, *2106*, *2107*, *2108*, *2109*, *2110*, *2111*, *2112*, *2113*, *2114*, *2115*, *2116*, *2117*, *2118*, *2119*, *2120*, *2121*, *2122*, *2123*, *2124*, *2125*, *2126*, *2127*, *2128*, *2129*, *2130*, *2131*, *2132*, *2133*, *2134*, *2135*, *2136*, *2137*, *2138*, *2139*, *2140*, *2141*, *2142*, *2143*, *2144*, *2145*, *2146*, *2147*, *2148*, *2149*, *2150*, *2151*, *2152*, *2153*, *2154*, *2155*, *2156*, *2157*, *2158*, *2159*, *2160*, *2161*, *2162*, *2163*, *2164*, *2165*, *2166*, *2167*, *2168*, *2169*, *2170*, *2171*, *2172*, *2173*, *2174*, *2175*, *2176*, *2177*, *2178*, *2179*, *2180*, *2181*, *2182*, *2183*, *2184*, *2185*, *2186*, *2187*, *2188*, *2189*, *2190*, *2191*, *2192*, *2193*, *2194*, *2195*, *2196*, *2197*, *2198*, *2199*, *2200*, *2201*, *2202*, *2203*, *2204*, *2205*, *2206*, *2207*, *2208*, *2209*, *2210*, *2211*, *2212*, *2213*, *2214*, *2215*, *2216*, *2217*, *2218*, *2219*, *2220*, *2221*, *2222*, *2223*, *2224*, *2225*, *2226*, *2227*, *2228*, *2229*, *2230*, *2231*, *2232*, *2233*, *2234*, *2235*, *2236*, *2237*, *2238*, *2239*, *2240*, *2241*, *2242*, *2243*, *2244*, *2245*, *2246*, *2247*, *2248*, *2249*, *2250*, *2251*, *2252*, *2253*, *2254*, *2255*, *2256*, *2257*, *2258*, *2259*, *2260*, *2261*, *2262*, *2263*, *2264*, *2265*, *2266*, *2267*, *2268*, *2269*, *2270*, *2271*, *2272*, *2273*, *2274*, *2275*, *2276*, *2277*, *2278*, *2279*, *2280*, *2281*, *2282*, *2283*, *2284*, *2285*, *2286*, *2287*, *2288*, *2289*, *2290*, *2291*, *2292*, *2293*, *2294*, *2295*, *2296*, *2297*, *2298*, *2299*, *2300*, *2301*, *2302*, *2303*, *2304*, *2305*, *2306*,

12: 713

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific information required.

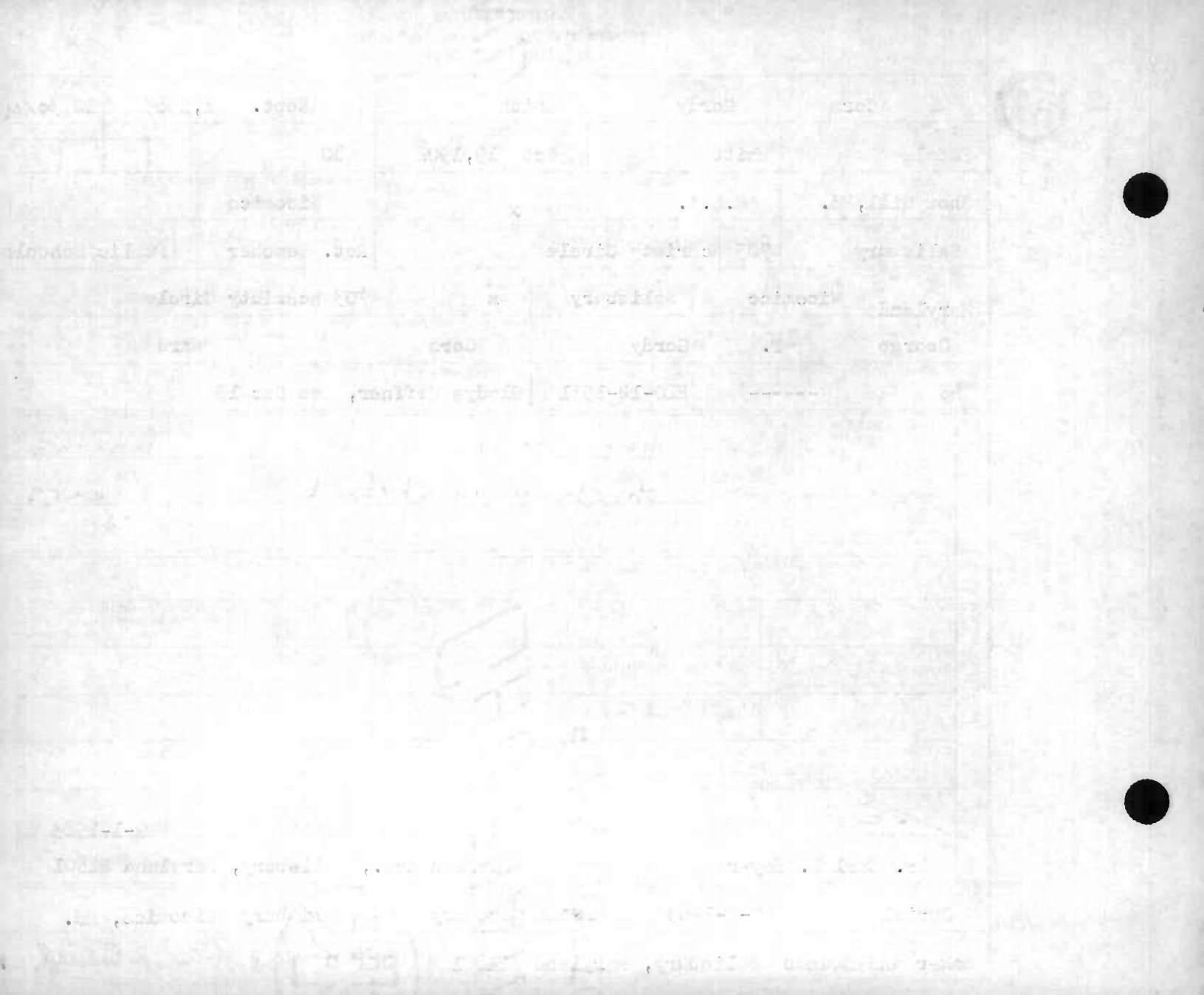
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   | REG. NO.        |   |
|---|--|--|--|---|-----------------|---|
| 1. FOR STATE REGISTRAR  |  |  | 2a. DATE OF DEATH                      |   | 2b. HOUR        |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Cora Gordy Smith</b>   |  |  | MONTH DAY YEAR<br><b>Sept. 1, 1983</b> |   | <b>12:30 AM</b> |   |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Oct 19, 1902</b>  |                 | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b>  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Snow Hill, Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                 | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Wicomico</b> MD.   |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>703 McBriety Circle</b>                 |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. Teacher</b>  |                 | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Public Schools</b>  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Wicomico</b>   |  | 13c. CITY OR TOWN<br><b>Salisbury</b>   |                 | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>George T. Gordy</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Cora Ward</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |                 |   |
| 16b. SOCIAL SECURITY NO.<br><b>220-12-1531</b>  |  | 17. INFORMANT ADDRESS<br><b>Gladys Heffner, See Sec 13</b>   |  |   |                 |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic melanoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>melanoma of Back</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1725</b> months<br><b>2 years</b> |  |  |  |   |                 |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |                 |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                 |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                 |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5-5</b> , 19 <b>80</b> , to <b>9-1</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>7-31</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |                 |   |
| 22b. SIGNATURE<br><i>Earl L. Royer</i>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>9-1-1983</b>   |                 |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Earl L. Royer</b>   |  | 22e. ADDRESS<br><b>Camden Ave., Salisbury, Maryland 21801</b>  |  |   |                 |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>9-3-1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Pargons Cemetery</b>   |                 | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Salisbury Wicomico, Md.</b>   |
| 24. FUNERAL DIRECTOR NAME<br><b>Baker and Bounds Salisbury, Maryland 21801</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 6 - 1983</b>  |                 |   |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>   |                 |   |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|-----------------|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH  |  |  | MONTH  |  |  | DAY  |  |  | YEAR            |  |  | 2b. HOUR                                     |  |  |
| FIRST MIDDLE LAST<br>Anna Barbara Somers   |  |  | SEPTEMBER 18, 1983   |  |  | 3 45   |  |  | P M  |  |  |                 |  |  |  |  |  |
| 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  |  | IF UNDER 1 YEAR |  |  | IF UNDER 24 HRS                              |  |  |
| Female   |  |  | Caucasian  |  |  | MONTH DAY YEAR<br>5 25 1901  |  |  | 82 YRS.  |  |  | 3 23            |  |  | HOURS MIN.                                   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |  |                 |  |  |  |  |  |
| Md   |  |  | U.S.   |  |  |  |  |  | Wicomico   |  |  |                 |  |  | MD.  |  |  |
| 11. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |                 |  |  |  |  |  |
| Salisbury  |  |  | Peninsula General Hospital   |  |  | Housewife  |  |  |  |  |  |                 |  |  |  |  |  |
| 13a. USUAL RESIDENCE (IF HAVING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  | 13b. INSIDE CITY LIMITS?   |  |  | 13c. STREET ADDRESS  |  |  |  |  |  |                 |  |  |  |  |  |
| 13a. STATE   |  |  | 13b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  |  | 13c. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | Md   |  |  | Somerset        |  |  | Princess Anne                                |  |  |
| 14. FATHER'S NAME (TYPE OR PRINT)  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |
| 14. FIRST MIDDLE LAST<br>William T. Laird  |  |  | 15. FIRST MIDDLE LAST<br>Nora Bozman   |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT  |  |  | ADDRESS  |  |  |                 |  |  |  |  |  |
| No   |  |  | 216-56-0010  |  |  | Mrs Gilbert Abbott   |  |  | Rt 3, Princess Anne, Md  |  |  |                 |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  |  |  |                 |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |
| IMMEDIATE CAUSE (a) RESPIRATORY ARREST   |  |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |
| 4360   |  |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |
| (b) CVA  |  |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |
| (c)  |  |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |
| SEPSIS   |  |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |                 |  |  |  |  |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |                 |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |                 |  |  |  |  |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION  |  |  | CITY OR TOWN   |  |  | COUNTY          |  |  | STATE  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  |  |  | STREET   |  |  |  |  |  |                 |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from AUG. 28, 1983, to SEPT. 18, 1983, that (I) (we) last saw the deceased alive on SEPT. 17, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |
| 22b. SIGNATURE   |  |  | DEGREE   |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |  | 22c. DATE SIGNED   |  |  |                 |  |  |  |  |  |
| Robert B. Allen  |  |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |
| ROBERT B. ALLEN  |  |  |  |  |  |  |  |  |  |  |  |                 |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION  |  |  | CITY OR TOWN    |  |  | COUNTY                                       |  |  |
| Burial   |  |  | 9/20/83  |  |  | Oriole   |  |  | Oriole   |  |  | Somerset        |  |  | Md   |  |  |
| 24. FUNERAL DIRECTOR   |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |                 |  |  |  |  |  |
| James O. Herman  |  |  | SEP 21 1983  |  |  | John J. Smith  |  |  |  |  |  |                 |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00000000

Penning's General Hospital

●

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |   |  |   |  |
|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Thomas F. Springer                               |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>SEPTEMBER 20, 1983 |   |  | 2b. HOUR<br>11:46 M   |  |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JUNE 19, 1946   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>37 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>3 1  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Ohio                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Wicomico MD   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Peninsula General Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>W. O. Covey                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Food |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |   |   |  |   |  |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Wicomico   |   | 13c. CITY OR TOWN<br>Sharptown  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>Rural Route 21861  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clyde Springer Jr.                            |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen Kenney   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----  |   | 17. INFORMANT<br>ADDRESS<br>Nancy L. Springer Sharptown, Md.  |  |   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

4148  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

## MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 9/20/83, 19 83, to 9/20, 19 83, that (I) (we) lost<br>saw the deceased alive on 9/20/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>MB Kerner M.D.   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>9/20/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |   |  |

|  |  |                        |  |  |  |  |  |
|--|--|------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIES<br>Burial                           |  | 23b. DATE<br>9-23-1983 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Laurel Hill Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Laurel Sussex Delaware |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Marvel-Short Funeral Home Delmar, Del. |  |                        |  | 25a. DATE REC'D. BY REGISTRAR<br>SEP 26 1983           |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner                         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Carl HENRY STEININGER

2a. DATE OF DEATH MONTH DAY YEAR  
September 14, 1983

2b. HOUR

2:50 A

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

Oct. 8, 1905

6. AGE (IN YEARS LAST BIRTHDAY)

77

YRS.

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Washington

7b. CITIZEN OF WHAT COUNTRY?

U. S.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Wicomico

MD.

10. CITY OR TOWN OF DEATH

Salisbury

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Deer's Head Center

12a. USUAL OCCUPATION

Farmer

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Worcester

13c. CITY OR TOWN

Snow Hill

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

209 Belt St.

21863

14. FATHER'S NAME

Charles

MIDDLE

Steininger

LAST

15. MOTHER'S MAIDEN NAME

Mary

MIDDLE

V.

LAST

Ellis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

212-14-4705

17. INFORMANT

ADDRESS 420 Patterson Ave

George T. Steininger, Salisbury, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

4292

IMMEDIATE CAUSE (a)

ASCVD

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Organic Brain Syndrome. Decubitus ulcers

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) lost  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

M. Shrestha

DEGREE

MD

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

M. Shrestha, M.D.

22e. ADDRESS

Deer's Head Center, Salisbury, Md. 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

9/17/83

23c. NAME OF CEMETERY OR CREMATORY

Bethel

23d. LOCATION CITY OR TOWN

Parsonsborg; Wicomico, Md

COUNTY

STATE

24. FUNERAL DIRECTOR

James L. Druman

ADDRESS

Princess Anne

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

SEP 19 1983

James J. Conner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a medical examination will be required.

BP \_\_\_\_\_



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |   |  |   |  |   |  | REG. NO.   |  |
|--|--|------------------|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HARRY A STURGIS</b>   |  |                  |  |   |  |   |  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>9</b> DAY <b>3</b> YEAR <b>1983</b> |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>B</b> |  | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>24</b> YEAR <b>24</b>                             |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>59</b> YRS. |  | IF UNDER 1 YR.<br>MONTHS <b></b> DAYS <b></b>   |  | 7b. HOUR <b>1040</b>   |  |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>   |  |                  |  | 7d. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 7e. DATE PRONOUNCED DEAD <b>9 3 1983</b>   |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH <b>WICOMICO MD.</b>   |  |                  |  | 10. CITY OR TOWN OF DEATH <b>SALISBURY</b>  |  |   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PENINSULA GENERAL</b>                         |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Laborer</b>  |  |                  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>  |  |   |  |   |  |  |  |
| 13a. STATE <b>MD.</b>  |  |                  |  | 13b. COUNTY <b>WORCESTER</b>  |  |   |  | 13c. CITY OR TOWN <b>POCOMOKE</b>   |  |  |  |
| 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |                  |  | 13e. STREET ADDRESS <b>718 Sixth St.</b>  |  |   |  | 21851   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Thomas</b> MIDDLE <b>Aydelotte</b> LAST <b>Sturgis</b>   |  |                  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Beatrice</b> MIDDLE <b>Sturgis</b> LAST <b>Sturgis</b> |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>  |  |                  |  | 16b. SOCIAL SECURITY NO. <b>218 16 7203</b>   |  |   |  | 17. INFORMANT ADDRESS <b>Catherine Sturgis 718-6th St. Pocomoke, Md.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b><br>1552<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>CARCINOMA LIVER</b><br>(c) <b></b>  |  |                  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Months</b><br><b>1 Year</b>                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |                  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                           |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)                                 |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                  |  |   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>John T. Bulkeley</b>   |  |                  |  | TITLE (SPECIFY) <b>DEPUTY</b>   |  |   |  | DATE SIGNED <b>9-3-83</b>   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN T. BULKELEY</b>  |  |                  |  | ADDRESS <b>SALISBURY, MARYLAND</b>  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                  |  | 23b. DATE <b>9-11-83</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Friendship Cem.</b>   |  |  |  |
| 23d. LOCATION<br>CITY OR TOWN <b>Wattsville</b> COUNTY <b>Accomack</b> STATE <b>Va.</b>  |  |                  |  | 24. FUNERAL DIRECTOR<br>NAME <b>Samuel H. Savage</b> ADDRESS <b>New Church, Va.</b>         |  |   |  | 25. DATE REC'D. BY REGISTRAR <b>SEP 14 1983</b>   |  |  |  |
| 25. REGISTRAR'S SIGNATURE <b>John J. Carlick</b>   |  |                  |  |   |  |   |  |   |  |  |  |

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 25577   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>James EDWARD TAYLOR</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>September 6, 1983</b>  |  |  |  |
| 3. SEX<br><b>male</b>   |  |  |  | 2b. HOUR<br><b>1:37 p.m.</b>  |  |  |  |
| 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Jan. 06, 1925</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                              |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Wicomico</b> MD.            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Deer's Head Center, Salisbury, MD</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>POULTRYMAN</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>POULTRY</b>                    |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>WICOMICO</b>   |  | 13c. CITY OR TOWN<br><b>PITTSVILLE</b>  |  | 13e. STREET ADDRESS<br><b>BOX 11</b>                                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>JOHN HENRY TAYLOR</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>GEORGIA ELIZABETH WEBB</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>WHIT</b>   |  |  |  |
| 17. INFORMANT ADDRESS<br><b>NEELIE DAVIS BOX 11 PITTSVILLE MD.</b>  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>COPD</b><br><b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____     |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Respirated CVA</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (we) (this hospital) attended the deceased from <b>June 27</b> , 19 <b>83</b> , to <b>Sept. 6</b> , 19 <b>83</b> , that (we) last saw the deceased alive on <b>Sept. 6</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (do) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>E. P. Ritchings, M.D.</b>  |  |  |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>9/6/83</b>                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>E. P. Ritchings, M.D., Deer's Head Center, Salisbury, MD</b>  |  |  |  | 22e. ADDRESS<br><b>21801</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>9/9/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>108 WILLIAMS ST BERLIN MD 21811</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                                |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Anna A. Burdette</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 14 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                    |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |  |  |  |  |   |  |  |  |
|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>SARAH ELIZA</b>   |  | FIRST <b>Tilghman</b>   |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>September 11, 1983</b>  |  | 2b. HOUR <b>0911</b> <sup>A</sup> <sub>M</sub> |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>AA</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>2-7-1928</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS                                 |  | IF UNDER 24 HRS. HOURS MIN.                    |  |
| 7. CITY OR TOWN OF DEATH <b>Salisbury</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                     |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.                                     |  |   |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>LABORER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |   |  |  |  |
| 13a. STATE <b>MD.</b>  |  | 13b. COUNTY <b>BETHEL</b>   |  | 13c. CITY OR TOWN <b>PRANNE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>183. B. 4 26 E. PRANNE. MD 21853</b> |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>MABEL WHITE</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HELEN C. TILGHMAN</b>         |  |  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input checked="" type="checkbox"/> OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO. <b>213-22-653</b>                                  |  | 17. INFORMANT ADDRESS <b>BRENDA TILGHMAN 183. B. 4 26 E. PRANNE</b>  |  |  |  |   |  |  |  |

|  |  |  |  |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uterine Sarcoma</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 1790   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |
| (c)  |  |  |  |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/10</b> 19 <b>83</b> , to <b>9/11</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>9/10</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.) |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>DAVID E. COWALL, M.D.</b>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>9/11/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID E. COWALL, M.D.</b>  |  | 22e. ADDRESS <b>1300 S. Division St. Salisbury, Md 21801</b>        |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>9-17-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>John Wesley</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pr. Anne, Somerset, Md. 21853</b>  |  |
| 24. FUNERAL DIRECTOR <b>Adelphi James, 407 Somerset Ave. Pr. Anne, Md</b>   |  | ADDRESS   |  | 25. DATE REC'D. BY REGISTRAR <b>SEP 19 1983</b>  |  |   |  |
|   |  |   |  | 26. REGISTRAR'S SIGNATURE <b>John J. Cowell</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 allows any injury, or other traumatic event, the medical examiner must be notified at once.



M.D. 11.2

Resident General Hospital

Report

M.D. JAMES P. WHITE

WHITE HELEN C. TILGNER

1933-1934



CO  
O  
%

CO



CO

1933-1934

1933-1934



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1-81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

25579

FOR  
STATE  
REGISTRAR

REG. NO.

|  |                       |  |   |   |  |
|--|-----------------------|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>AMANDA S. Trader</b>  |                       |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 8, 1983</b> |   | 2b. HOUR<br><b>9:00 P.M.</b>                 |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>Blk</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>2-24-96</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Lincoln Del.</b>   |                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  |                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Peninsula General Hospital</b> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Wicomico</b> MD.   |  |
| 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>Domestic</b>  |                       | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Housewife</b>  |   |   |  |
| 13a. STATE<br><b>Md.</b>   |                       | 13b. COUNTY<br><b>Wicomico</b>   | 13c. CITY OR TOWN<br><b>Salisbury</b>                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNKNOWN</b>   |                       | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cecilia Shockley</b>   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |                       | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |   | 17. INFORMANT<br>ADDRESS<br><b>LAURA TINGLE Rt #253G Seaford Del.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1539</b> IMMEDIATE CAUSE (a) <b>colon adenocarcinoma Rt #253G</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                       |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____   |                       |  |   |   |  |
| 19a. DATE OF OPERATION   |                       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                       | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                       | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Sept. 5, 1983</b> , to <b>Sept. 8, 1983</b> , that (I) (we) lost<br>saw the deceased alive on <b>Sept. 8, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did not) view the body after death.                            |                       |  |   |   |  |
| 22b. SIGNATURE<br><b>Rodney A. Wenrich</b>   |                       | DEGREE<br><b>MD.</b>   |   | 22c. DATE SIGNED<br><b>Sept. 8, 1983</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RODNEY A. WENRICH</b>  |                       | 22e. ADDRESS<br><b>100 POWER ST. SALISBURY Md.</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |                       | 23b. DATE<br><b>9-17-85.</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Old Hickory</b>  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Lincoln Sussex Del.</b>   |                       | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 23 1983</b>  |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Jolley Memorial Chapel - Salis. Md.</b>   |                       | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |   |   |  |



Blanche 25 1/2  
F. 2 1/2  
K. 2 1/2  
L. 2 1/2  
M. 2 1/2  
N. 2 1/2  
O. 2 1/2  
P. 2 1/2  
Q. 2 1/2  
R. 2 1/2  
S. 2 1/2  
T. 2 1/2  
U. 2 1/2  
V. 2 1/2  
W. 2 1/2  
X. 2 1/2  
Y. 2 1/2  
Z. 2 1/2

John 25 1/2  
Robert 25 1/2  
William 25 1/2  
James 25 1/2  
George 25 1/2  
Charles 25 1/2  
Thomas 25 1/2  
Richard 25 1/2  
Henry 25 1/2  
John 25 1/2  
Robert 25 1/2  
William 25 1/2  
James 25 1/2  
George 25 1/2  
Charles 25 1/2  
Thomas 25 1/2  
Richard 25 1/2  
Henry 25 1/2

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25580

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |         |   |  |  |  |  |  |                                |  |                                      |  |  |  |  |  |   |  |   |  |
|---|---------|---|--|--|--|--|--|--------------------------------|--|--------------------------------------|--|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST                                       |  | MIDDLE   |  | LAST   |  | 20. DATE KNOWN OF DEATH        |  | 21. DATE KNOWN OF DEATH              |  | 22. DATE KNOWN OF DEATH                            |  | 23. DATE KNOWN OF DEATH                                  |  | 24. HOUR  |  |   |  |
| Harrison  |         | Trader                                      |  |  |  |  |  | 9 3 19 83                      |  | 9 3 19 83                            |  | 9 3 19 83  |  | 9 3 19 83  |  | 11:32   |  |   |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH                            |  | 6. AGE (IN YEARS)                                    |  | IF UNDER 1 YR.   |  | IF UNDER 24 HRS.               |  | 20. DATE KNOWN OF DEATH              |  | 21. DATE KNOWN OF DEATH                            |  | 22. DATE KNOWN OF DEATH                                  |  | 23. DATE KNOWN OF DEATH                                       |  |   |  |
| Male  | Black   | 7-9-28                                      |  | 55 YRS.  |  |  |  |                                |  | 9 3 19 83                            |  | 9 3 19 83  |  | 9 3 19 83  |  | 11:32   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?                |  | 8. MARRIED   |  | NEVER MARRIED  |  | DIVORCED                       |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  | 10. CITY OR TOWN OF DEATH                          |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Md.   |         | U.S.A.                                      |  | WIDOWED  |  | NEVER MARRIED  |  | DIVORCED                       |  | Wicomico County, MD.                 |  | Salisbury  |  | Peninsula General Hospital                               |  | Disable   |  |   |  |
| 13a. STATE  |         | 13b. COUNTY                                 |  | 13c. CITY OR TOWN                                    |  | 13d. INSIDE CITY LIMITS?   |  | 13e. STREET ADDRESS            |  | 14. FATHER'S NAME                    |  | 15. MOTHER'S MAIDEN NAME                           |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?             |  | 16b. SOCIAL SECURITY NO.                                      |  | 17. INFORMANT   |  |
| Penn.   |         |   |  | Philadelphia   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |  | 2039 N. 32 St.                 |  | Wallace Brittingham                  |  | Maggie Trader                                      |  | yes  |  | 218-20-7642   |  | Maggie Trader-3126 Montgomery Ave                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         | PART 1 DEATH WAS CAUSED BY:                 |  | IMMEDIATE CAUSE (a)                                  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | DUE TO, OR AS A CONSEQUENCE OF |  | DUE TO, OR AS A CONSEQUENCE OF       |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  | 19a. DATE OF OPERATION                                   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?             |  | 20. BODY ONLY   |  |
| 4292  |         |   |  | Arteriosclerotic cardiovascular disease              |  |  |  |                                |  |                                      |  |  |  |  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |         |   |  |  |  |  |  |                                |  |                                      |  |  |  |  |  |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH                 |         | 21b. TIME OF INJURY                         |  | 21c. HOW INJURY OCCURRED                             |  | 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY           |  | 21f. LOCATION                        |  | 21g. CITY OR TOWN                                  |  | 21h. COUNTY  |  | 21i. STATE  |  |   |  |
|   |         | HOUR A.M. MONTH DAY YEAR                    |  | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  | WHILE NOT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> |  | STREET, FACTORY, FARM, ETC.)   |  | STREET                               |  |  |  |  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on   |         | Autopsy <input checked="" type="checkbox"/> |  | Inspection <input type="checkbox"/>                  |  | Inquiry <input type="checkbox"/>   |  | and in my opinion              |  | death resulted from:                 |  | Natural causes <input checked="" type="checkbox"/> |  | Accident <input type="checkbox"/>                        |  | Suicide <input type="checkbox"/>                              |  | Homicide <input type="checkbox"/>                                   |  |
| ACTUAL SIGNATURE  |         | TITLE (SPECIFY)                             |  | DATE SIGNED  |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)                                |  | 23b. DATE                      |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION                                      |  | 23e. COUNTY  |  | 23f. STATE  |  |   |  |
| Thomas D. Smith   |         | MD Deputy Chief                             |  | 9/5/83   |  | Burial   |  | 9-10-83                        |  | Wharton Cem.                         |  | Parksley   |  | Accomack, Va.  |  |   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |         | ADDRESS                                     |  | 24. FUNERAL DIRECTOR                                 |  | 24a. DATE REC'D. BY REGISTRAR  |  | 24b. REGISTRAR'S SIGNATURE     |  | 25a. DATE REC'D. BY REGISTRAR        |  | 25b. REGISTRAR'S SIGNATURE                         |  |  |  |   |  |   |  |
| Thomas D. Smith, M.D.   |         | 111 Penn St. Balto., MD.                    |  | Edgar Wharton  |  | 1 SEP 14 1983  |  | John J. Conner                 |  |                                      |  |  |  |  |  |   |  |   |  |



DWDE W

REPT VCTNO



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |  |  |  |  |   |   |  |
|--|--|--|---|--|--|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Russell James Turner</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>AUGUST</b> DAY <b>18</b> YEAR <b>1983</b> |  |  | 2b. HOUR<br><b>11:50 A.M.</b>  |  |  |   |   |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>AA</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>11</b> YEAR <b>28</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>54</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>                                       |   | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Wicomico</b> MD.                          |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Peninsula General Hospital</b> |   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>LABOR</b>     |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b></b>        |   |  |
| 13a. STATE<br><b>MD</b>  |  | 13b. COUNTY<br><b>Summers</b>  |   | 13c. CITY OR TOWN<br><b>Towmoke</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>871 Pomeroy 21851-0000</b>                                 |   |   |  |
| 14. FATHER'S NAME<br>FIRST <b>JAMES</b> MIDDLE <b>H</b> LAST <b>TURNER</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>LOUISE</b> MIDDLE <b>ELIZ</b> LAST <b>TURNER</b>  |  |  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>215-26-4191</b>   |  | 17. INFORMANT<br><b>Helen H. Hall</b>  |  |  |   | ADDRESS<br><b></b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>5188</b> IMMEDIATE CAUSE (a) <b>Pulmonary fibrosis &amp; severe</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary insufficiency</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>                     |  |  |   |  |  |  |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b></b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |   |  |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  |  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8/16/83</b> to <b>8/18/83</b> that (I) (we) last saw the deceased alive on <b>8/16/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |  |   |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  |  |   | DEGREE   |  |  |  | 22c. DATE SIGNED   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>OSWALD J BURTON</b>  |  |  |   | 22e. ADDRESS<br><b>100 POWER STREET<br/>SALISBURY MD 21801</b>   |  |  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>   |  |  |   | 23b. DATE<br><b>8-24-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Christ Mt Cem</b>                           |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE          |   |  |
| 24. FUNERAL DIRECTOR<br><b>Foley Funeral Home</b>  |  |  |   | ADDRESS<br><b>W 35th Rd Salisbury MD</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>AUG 25 1983</b>                                  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b> |   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED  
GENERAL HOSPITAL

11-10-1918

General Hospital

CHIEF



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FRANCES EDWARDS VAN ALKEN</b> |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>SEPTEMBER 18 1983</b> |   |  | 2b. HOUR<br><b>08 30 M</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 5 1900</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Jersey</b>       |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Wicomico</b> MD.                                     |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>                        |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Peninsula General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>Wicomico</b>   |  | 13c. CITY OR TOWN<br><b>Pittsville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRANK B EDWARDS</b>     |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNIE I LEATHERWOOD</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>214-74-2733</b>  |  |
| 17. INFORMANT<br>ADDRESS<br><b>Evelyn Liechty Sec Sec 13A.</b>       |  |  |  |   |  |   |  |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Myocardial + Cardiac failure**

DUE TO, OR AS A CONSEQUENCE OF

5740  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **Acute myocardial**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Acute cholecystitis + cholelithiasis**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Advanced atherosclerotic vascular disease**19a. DATE OF OPERATION  
**9-9-83**19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  
**Acute cholecystitis + pancreatitis**20a. AUTOPSY?  
YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?  
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK NOT AT WORK

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from **9-7**, 19 **83**, to **9-18**, 19 **83**, that (I) (we) lost  
saw the deceased alive on **9-17**, 19 **83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

ATTENDING  
PHYSICIANMEDICAL  
DIRECTORSTAFF  
PHYSICIAN

9-18-83

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION  
(CITY OR TOWN)

COUNTY

STATE

24. FUNERAL DIRECTOR

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in case.



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JACK PERRY VANCE</b>                    |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>SEPTEMBER 7 1983</b> |   |  | 2b. HOUR <b>0750 M</b>  |  |
| 3. SEX <b>MALE</b>   |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>2 4 1886</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b> YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Wicomico</b> MD.                          |  |
| 10. CITY OR TOWN OF DEATH <b>Salisbury</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE) <b>COAL MINER</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY <b>Self Emp.</b>                             |  | 13a. STREET ADDRESS <b>Box 721</b>  |  |   |  |   |  |
| 13b. CITY OR TOWN <b>Worcester</b>   |  | 13c. CITY OR TOWN <b>Libertytown</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. ADDRESS <b>21811</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Vance</b>                        |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie Skeens</b>   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b> |  | 16b. SOCIAL SECURITY NO. <b>224-12-6793</b>   |  | 17. INFORMANT ADDRESS <b>Box 721 Berlin, Md 21811</b>   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Pulmonary Metastases**

1629

CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.

(b) **Hyper nephroma Left Kidney**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Arteriosclerotic Heart disease, Ch. Arterial Hypertension, Pulm edema**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Arteriosclerotic Heart disease, Ch. Arterial Hypertension, Pulm edema**

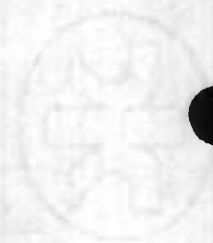
|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/4/83</b> , 19____, to <b>9/7/83</b> , 19____, that (I) (we) last saw the deceased alive on <b>9/6</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE <b>B. K. Agarwal</b>  |  | DEGREE  |  |   |  | 22c. DATE SIGNED <b>9/7/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BAL K AGARWAL</b>   |  | 22e. ADDRESS <b>PGHMC Salisbury Md 21801</b>                        |  |   |  |  |  |

|   |  |                              |  |  |  |  |  |
|---|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b> |  | 23b. DATE <b>9/10/1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Springhill Mem Ga.</b> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hebron Wic Md</b> |  |
| 24. FUNERAL DIRECTOR <b>BAKER &amp; BOUNDS</b>          |  | ADDRESS <b>SALISBURY, MD</b> |  | 25a. DATE REC'D. BY REGISTRAR <b>SEP 13 1983</b>             |  | 25b. REGISTRAR'S SIGNATURE <b>James J. Gough</b>             |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Baltimore Health Department, Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



26000 + 25000

*[Faint mirrored bleed-through from the reverse side of the page]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | REG. NO.   |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JAMES R Warwick</b>  |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>September 17, 1983</b>      |   |  | 2b. HOUR<br><b>0219 M</b>  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>CAUC.</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>7 13 1907</b>  |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY) <b>76</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(COUNTRY) <b>Md</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Wicomico</b> MD.                                     |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Peninsula General Hospital</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Delmarva Power</b>   |  |
| 13a. STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Wicomico</b>   |  | 13c. CITY OR TOWN<br><b>Fruitland</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>113 Oaklee Drive 21826</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>James U Warwick</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Beula Jackson</b> |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214 10 7418</b>   |  | 17. INFORMANT<br>ADDRESS <b>Mrs Cleona Warwick, 113 Oaklee Dr. Fruitland Md</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Concise Arret</b><br><b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>YRS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>YRS</b> |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/13</b> 19 <b>83</b> to <b>9/17</b> 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>7/13</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>D. M. Wood, MD</b>   |  |  |  | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br><b>9/17/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D. M. WOOD, MD</b>  |  |  |  | 22e. ADDRESS<br><b>P-H-M-C</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>9/20/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parsons Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Salisbury Wicomico Md</b>                      |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>James J. Hession</b> ADDRESS <b>Princess Anne, Md</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>SEP 21 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conish</b>   |  |  |  |

21

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

25585

REG. NO.

|  |                    |  |  |  |   |   |  |  |
|--|--------------------|--|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EVELYN M. WHARTON</b>   |                    |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>9-18-83</b>  |  |   | 2b. HOUR <b>0915</b>  |  |  |
| 3. SEX <b>F</b>  | 4. RACE <b>Blk</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>12 30 26</b> | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY) <b>56</b> YRS.  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN. | 7c. DATE PRONOUNCED DEAD <b>9-18-83</b> | 2d. HOUR <b>11</b> AM   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Salisbury</b>   |                    |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 9. CITY OR TOWN OF DEATH <b>Salisbury</b>  |                    |  | 10. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Peninsula General Hospital</b> |  |   | 11. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Wicomico</b>  |  |  |
| 12. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>12a. STATE <b>MD</b> 12b. COUNTY <b>Worcester</b> 12c. CITY OR TOWN <b>Girdlefree</b>  |                    |  | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   | 13b. STREET ADDRESS <b>Rt #1 Box 70 21829</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <b>PAUL Dutton</b>  |                    |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Goldie TRADER</b>   |  |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |  |
| 17a. SOCIAL SECURITY NO. <b>136-22-1116</b>  |                    |  | 17b. INFORMANT <b>NATHANIEL R. Wharton</b>   |  |   | 17c. ADDRESS <b>Add. Same AS ABOVE</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4939</b> IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Bronchial Asthma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  |                    |  |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><br><b>years</b> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |                    |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |                    |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                    |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                    |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |                    |  |  |  |   |   |  |  |
| ACTUAL SIGNATURE <b>[Signature]</b>  |                    |  | TITLE (SPECIFY) <b>Deputy</b> M.D. MEDICAL EXAMINER  |  |   | DATE SIGNED <b>9-19-83</b>  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Earl L. Royer, M.D.</b>   |                    |  | ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>   |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |                    |  | 23b. DATE <b>9-23-83</b>   |  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>GREEN ACRES</b>   |  |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Salisbury Wico Md.</b>   |                    |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>Jolley Funeral Home, Salisbury, Md.</b>  |  |   | 25a. DATE REC'D. BY REGISTRAR <b>SEP 23 1983</b>  |  |  |
| 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |                    |  |  |  |   |   |  |  |



W. J. DOWD

03012/110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

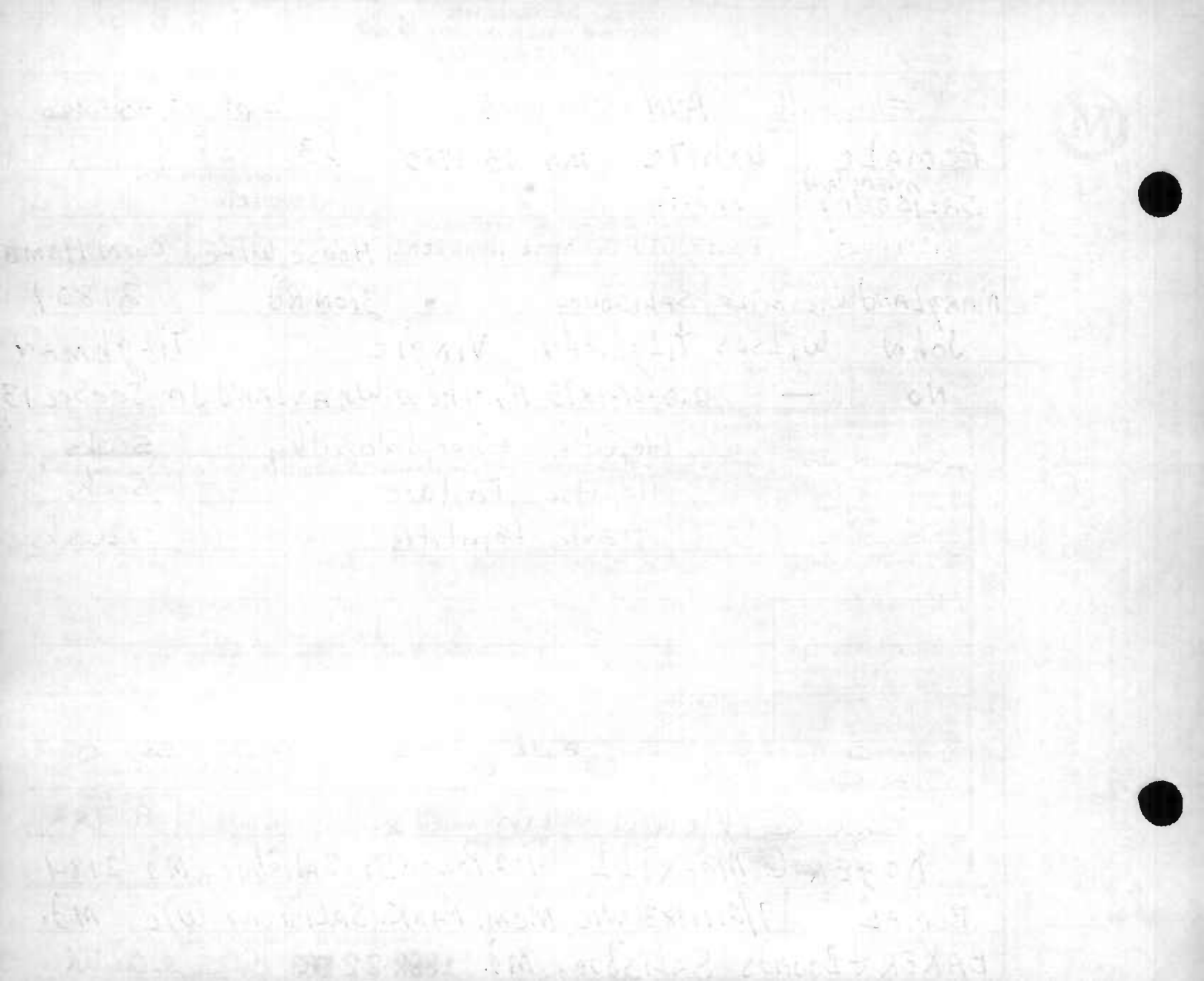
25586

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Elizabeth ANN Whayland.  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 17, 83   |   | 2b. HOUR<br>5 10 PM   |
| 3. SEX<br>Female  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>JAN 25 1920   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>63 YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE<br>STATE OF MARYLAND<br>SALISBURY  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Wicomico MD.  |   |   |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Peninsula General Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>House Wife                  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home                                 |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |   | 13b. CITY OR TOWN<br>Wicomico   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE<br>310N RD 21801                               |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Wilson Tilghman  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Virgie Tilghman  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-09-1695  |   | 17. INFORMANT<br>ADDRESS<br>Mayhew Whayland Jr See Sec 13                     |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Hepatic Encephalopathy<br>5733<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Hepatic Failure.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Toxic Hepatitis                            |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>5 wks.<br>5 wks.<br>7 weeks.   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |   |   |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 8.12.1983 to 9.17.1983, that (II) (we) lost<br>saw the deceased alive on 9.17.1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) did (did not) view the body after death. |   |   |   |   |   |
| 22b. SIGNATURE<br>Roger C Merrill   |   | DEGREE<br>MD  |   | 22c. DATE SIGNED<br>9.17.83   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROGER C MERRILL  |   | 22e. ADDRESS<br>102 Bowen St Salisbury, MD 21801  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  | 23b. DATE<br>9/21/1983  | 23c. NAME OF CEMETERY OR CREMATORY<br>Wic. Mem. Park.   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Salisbury Wic. MD.              |   |
| 24. FUNERAL DIRECTOR<br>NAME<br>BAKER & BOUNDS  |   | ADDRESS<br>Salisbury, Md.   |   | 25a. DATE REC'D. BY REGISTRAR<br>SEP 22 1983                                  | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>RUTH Anderson WHITE |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>Sept. 24 1983                                 |   | 2b. HOUR<br>2:05 PM   |
| 3. SEX<br>FEMALE  | 4. RACE<br>CAUCASIAN  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 2 1892  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS.                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>DEALISLAND                         | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Wicomico MD.          |   |
| 10. CITY OR TOWN OF DEATH<br>Salisbury  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Peninsula General Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired Buyer |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Depto. Store   |
| 13a. STATE<br>Maryland  |   |   | 13b. COUNTY<br>Wicomico   | 13c. CITY OR TOWN<br>Salisbury                                | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Levin Albert Anderson                 |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mann Goslee                      |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO      |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-10-7806  |   | 17. INFORMANT<br>ADDRESS<br>Steven Run Lane<br>Salisbury, Md. |   |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4310

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4 days.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>     | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |
| 22a. I certify that (this hospital) attended the deceased from Sept. 20, 1983, to Sept. 24, 1983, that (I) (we) last saw the deceased alive on Sept. 24, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br>Allen W. Tustin, M.D.   |  |  |  | 22c. DATE SIGNED<br>9/24/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Allen W. Tustin  |  |  |  | 22e. ADDRESS<br>32 Wesley Dr., Salisbury, Md. 21801                           |  |

|   |                        |  |   |
|---|------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial | 23b. DATE<br>9/27/1983 | 23c. NAME OF CEMETERY OR CREMATORY<br>White Family Cem | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Shad Point Wic Md |
| 24. FUNERAL DIRECTOR<br>NAME<br>Baker & Bounds      |                        | 25a. DATE REC'D. BY REGISTRAR<br>SEP 28 1983           |   |
| 25b. REGISTRAR'S SIGNATURE<br>John J. Connel        |                        |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP



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Wisconsin

Peninsula General Hospital

Salisbury

Leaving Hospital

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

25588

1- STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |                              |  |  |
|---|--|--|---|---|------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John F. Wilbur</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>SEPTEMBER</b> DAY <b>5</b> YEAR <b>1983</b> |   | 2b. HOUR<br><b>8:15 A.M.</b> |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Cauc.</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>SEPT.</b> DAY <b>22</b> YEAR <b>1917</b>   |                              | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Vermont</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                              | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Wicomico</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Salisbury</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Peninsula General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Civil Servant</b>  |                              | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. Gov't</b>   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Wicomico</b>   |   | 13c. CITY OR TOWN<br><b>Ocean City</b>  |                              | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST <b>John Edward</b> MIDDLE <b>Wilbur</b> LAST   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Laura</b> MIDDLE <b>L.</b> LAST <b>Roberts</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>  |                              | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW11-1965</b>  |  |
| 17. INFORMANT<br><b>Ruth K. Wilbur</b>  |  | ADDRESS<br><b>11604 Coastal Hwy</b>  |   | CITY OR TOWN<br><b>Ocean City</b>   |                              | STATE<br><b>MD</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiogenic Shock, CHF</b><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) |  |  |   |   |                              |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                              | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                              |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/4/83</b> to <b>9/5/83</b> that (I) (we) lost<br>saw the deceased alive on <b>9/5/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |                              |  |  |
| 22b. SIGNATURE<br><b>Raffetto</b>   |  | DEGREE<br><b>MD</b>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |                              | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RAFFETTO</b>  |  | 22e. ADDRESS<br><b>SGH</b>   |   |   |                              |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>9/8/83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |                              | 23d. LOCATION<br>CITY OR TOWN <b>Arlington, VA.</b> COUNTY STATE   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Murphy Funeral Home</b><br>ADDRESS <b>4510 Wilson Blvd. Arlington, VA.</b>  |  |  |   | 25a. DATE RECD. BY REGISTRAR<br><b>SEP 15 1983</b>  |                              |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Peninsula General Hospital

Library

100% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  | REG. NO.                                      |  |
|---|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Rachel Bennett Willin |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>9 24 1983 |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>1 29 1933   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br>50 YRS.  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Sharptown  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>702 MAIN ST. |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Wicomico MD.   |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Wicomico  |  | 13c. CITY OR TOWN<br>Sharptown   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Gordy Bennett  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Fannie Robinson  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE)<br>Florist   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>214-30-9026  |  | 17. INFORMANT ADDRESS<br>Benjamin F. Willin 702 MAIN ST. Sharptown, Md.  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>1629 IMMEDIATE CAUSE (a) Respiratory Insufficiency due to widespread lung metastasis from Carcinoma of lung<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Joseph A. Grasso  |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>9/26/83  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Joseph A. Grasso   |  | 22e. ADDRESS<br>1300 S. Division St., Salisbury Md.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>9/27/1983   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mardela Cem.   |   |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Mardela, Wicomico Md.  |  | 23e. DATE RECEIVED BY REGISTRAR'S OFFICE<br>SEP 29 1983  |  | 23f. REGISTRAR'S SIGNATURE<br>John J. [Signature]  |   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br>Baker + Bounds Salisbury, Md 21801   |  |  |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert card on papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |  |   |                                   |  | REG. NO.                                     |  |
|--|--|--|---|--|--|--|---|-----------------------------------|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |   |  | 25590                                    |  |   |                                   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |   |  | 2a. DATE OF DEATH                        |  |   | MONTH DAY YEAR                    |  | 2b. HOUR                                     |  |
| JOHN E. WOOLLEY  |  |  |   |  | 9-29-83                                  |  |   | 9:49A                             |  | M  |  |
| 3. SEX   |  | 4. RACE  |   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS.                             |  |
| Male   |  | Caucasian  |   | Oct. 12, 1910  |  | 72   |   | MONTHS DAYS                       |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |                                   |  |  |  |
| Pennsylvania   |  | USA  |   |  |  | Wicomico MD.   |   |                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |
| Salisbury  |  | Peninsula General Hospital   |   |  |  | security guard   |   | RR                                |  |  |  |
| 13a. STATE   |  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                        |  | 13d. INSIDE CITY LIMITS?  |                                   | 13e. STREET ADDRESS / ZIP CODE                                 |  |  |
| Delaware   |  |  | Sussex  |  | Laurel                                   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 806 West St. 99999   |  |  |
| 14. FATHER'S NAME  |  |  |   |  | 15. MOTHER'S MAIDEN NAME                 |  |   |                                   |  |  |  |
| FIRST MIDDLE LAST  |  |  |   |  | FIRST MIDDLE LAST                        |  |   |                                   |  |  |  |
| unknown  |  |  |   |  | unknown                                  |  |   |                                   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |   |  | 16b. SOCIAL SECURITY NO.                 |  | 17. INFORMANT   |                                   |  |  |  |
| no   |  |  |   |  | 172 01 3881                              |  | Midia L. Woolley 806 West St Laurel Del 19956                       |                                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |   |  |  |  |   |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |   |  |  |  |   |                                   |  |  |  |
| IMMEDIATE CAUSE (a) SEPSIS   |  |  |   |  |  |  |   |                                   |  |  |  |
| 2019   |  |  |   |  |  |  |   |                                   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |  |  |   |                                   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |   |  |  |  |   |                                   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |   |  |  |  |   |                                   |  |  |  |
| (c)  |  |  |   |  |  |  |   |                                   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |   |  |  |  |   |                                   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |  |  | 20a. AUTOPSY?   |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |
|  |  |  |   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |                                   |  |  |  |
|  |  |  | HOUR A.M. MONTH DAY YEAR  |  |  |  |   |                                   |  |  |  |
|  |  |  | P.M. 19   |  |  |  |   |                                   |  |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION  |   |                                   |  |  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  |   |  |  | STREET CITY OR TOWN COUNTY STATE   |   |                                   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 19 83, to 9/09 19 83, that (I) (we) lost saw the deceased alive on 7/29 19 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |   |                                   |  |  |  |
| 22b. SIGNATURE   |  |  |   |  | DEGREE                                   |  |   | 22c. DATE SIGNED                  |  |  |  |
| DAVID E. COLL  |  |  |   |  | MD                                       |  |   | 9-29-83                           |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |   |  | 22e. ADDRESS                             |  |   |                                   |  |  |  |
| DAVID E. COLL, M.D.  |  |  |   |  | 1300 S. Division St. Salisbury, MD 21801 |  |   |                                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY       |  |   | 23d. LOCATION                     |  |  |  |
| burial   |  |  | 10/3/83   |  | Odd Fellows Cemetery                     |  |   | Laurel Sussex Delaware            |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR            |  |   | 25b. REGISTRAR'S SIGNATURE        |  |  |  |
| NAME   |  |  |   |  | ADDRESS                                  |  |   |                                   |  |  |  |
| Homer L. Disharoon box 678 Laurel Del 19956  |  |  |   |  |  |  |   |                                   |  |  |  |

MEDICAL CERTIFICATION

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